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**Experiences of Pre-eclampsia:
Developing the Feminist Critique of Medicalised
Childbirth**

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Abstract

This thesis explores women's experiences of pre-eclampsia and attempts to construct a critique of the existing feminist challenge to medicalised childbirth. The argument presented here suggests that an analysis of the experiences of women with serious pregnancy complications is required to develop this challenge, which presently results in the marginalisation of such women. This thesis does not claim to present a fully developed critique of medicalised childbirth. Rather, it intends to present a challenge to the existing conventional feminist critique and identify a possible way forward whereby such development might be attained. Based on a self-selecting sample of thirty women, all of whom had experienced pre-eclampsia, the research explored their changing perceptions of pregnancy, their subjective experiences of pre-eclampsia and their ideas on how improvements might be made to health care provision. Face-to-face and telephone interviews were the primary methods, but some women chose to supply written accounts of their experiences guided by the thematic scheme of the interview schedule. A subset of six interviews and written accounts of the women's significant others, namely their husbands and mothers, was also included. The analysis strategy adopted was informed by the principles of grounded theory. The contribution of the thesis lies, firstly, in challenging conventional feminist assumptions that have provided the foundation for the existing critique of medicalised childbirth. It is suggested that these assumptions can be understood as deriving from the way in which the challenge has been constructed within the constraints of binary thinking. Secondly, the thesis begins the process of remedying this problem by raising the possibility of an approach which is constructed beyond binary thinking, aided partly through an analysis of the construction of risk by childbearing women. This theoretical suggestion is then related, more briefly, to maternity policy and midwifery practice.

Acknowledgements

The process of researching and writing this thesis began eight years ago. Eight years has been a long time to remain committed to a piece of work which had no career aspirations attached but rather reflected a simple desire to give voice to experiences that had largely been ignored. However, whilst that personal motivation partly inspired my continuation, the fact that I did actually survive long enough to make it to the stage of submission is mainly testimony to the support of various people. Primarily, I would like to thank Professor Celia Davies and Dr Fiona Brooks for their constant support, wisdom and inspiration. As I struggled through many intellectual and personal crises over the years they continued to stand by me when no doubt many others would have given me up as a lost cause. I have much to thank them for.

My daughter has had to put up over the years with a mother endlessly looking at a computer screen and my parents, a daughter who required lifts and childcare. Many friends encouraged me during those numerous occasions when I had concluded that this work was never going to be completed and that I should quit. My thanks go to all of them.

Ultimately, this thesis could not exist without the women who chose to share their experience of pre-eclampsia with me. They knew I was but a student and yet trusted me with their stories. I am very grateful to them. My thanks also goes to the husbands and mothers of these women who so generously also gave me their time and stories.

Chapter One

Introduction

A central theme in feminist literature concerned with women's reproductive health is the transformation of pregnancy from an essentially natural female-assisted event, to a medically controlled occurrence whose normality is defined only in retrospect. Many have argued that such medicalisation has often proved detrimental for women, physically, socially and psychologically. Maternity policy has not ignored such criticisms. The Department of Health's '*Changing Childbirth*' report (Department of Health, 1993), clearly states that 'pregnancy is not a pathological process or a disease' (Foreword). For some, these policy changes suggested a developing process of de-medicalisation. Through this, women would have the opportunity to successfully reinstate their control over their own bodies. Others remained sceptical. Feminist academic concern with pregnancy and birth as a sphere within which issues of social control and the power of patriarchal ideology are so well highlighted, however, would seem to have now largely petered out. That pregnancy and childbirth should remain a central issue for research is one conclusion I would hope the reader arrives at as a result of reading this thesis.

Existing contributions have largely overlooked the experiences of women whose pregnancy becomes affected by serious complications. By taking as a starting point not the issue of problematising normal pregnancies but rather the presence of problematic pregnancies, I hope this research will stimulate more discussion and debate. To accept as a fact that not all pregnancies are normal and safe would appear to be accepting one of the fundamental justifications of the medicalisation of pregnancy: the assumption of pathology.

However, I suggest that there is a fundamental difference between assuming pathology in all pregnancies, thereby lending ideological support to a system of care which often proves more detrimental than advantageous to many women, and recognising the existence of serious complications which raise issues for many existing feminist analyses of medicalised childbirth. There is a need to explore, through the lived experiences of women themselves, the ways in which serious problems in pregnancy are constructed and responded to within the medical model and alternative models of childbirth. Only then can the experiences of women who suffer serious complications be integrated within a developed critique of medicalised childbirth as opposed to being ignored or promoted as a justification and defence of it.

There are many and varied complications which may occur in pregnancy. I chose to focus upon pre-eclampsia for several reasons, including its relative commonality as a serious complication, its 'hidden' nature until a serious stage which often renders it an acute episode resulting in unexpected high levels of surveillance and intervention, and the lack of any cure, apart from the cessation of the pregnancy. Primarily, however, I chose pre-eclampsia because of my own personal experience of it and my desire to give a voice to women about their experiences, which I had myself felt was so lacking. I felt that women's experiences had to be explored, not simply in relation to the interventionist strategies which define modern obstetrics, but also in relation to alternative models of childbirth which promote notions of women's control and autonomy. Women who experience serious complications are not only subjected to high levels of obstetric supervision and intervention, but are also marginalised from the conception of childbirth integral to alternative models of childbirth. I was interested in the consequences of the former and the latter upon women's experience of pre-eclampsia.

The research is not presented as a definitive account of pregnancy complications but

rather as an account by some women of their experiences of one specific complication. Nevertheless, I hope it to be an account which shows the limitations of previous critiques of medicalised childbirth and the problem of assuming that alternatives like that of the natural childbirth model provide a liberating context for all childbearing women. Primarily, I hope it to be an account which makes clear the need, not only to listen to the voices of such women, but to respond to them in terms of strategies of health care.

After isolating the study's aims and objectives, I then briefly present a description of pre-eclampsia, the consequences of the illness and the level of its occurrence in the UK. This first chapter of the thesis is completed by a summary account of my own experience of pre-eclampsia. My story is placed here firstly, to make known my personalised relationship to the subject matter of my research. The possible implications of this are considered in Chapter Three. My story is placed at this point in the thesis also to focus the reader on the individual nature of the experience, something which despite attempts to the contrary, can easily become lost in the presentation of academic thematic constructions. I want the reader to attend to the lived individual nature of pre-eclampsia before embarking on what is an intellectualisation of women's experiences.

One objective of the research is to critically develop the feminist critique of the medicalisation of childbirth. The related literature is therefore reviewed in Chapter Two. A review of the feminist challenge is presented in the context of a summary of the emergence of medicalised childbirth. I attempt to show the limitations of both this literature and that which has been concerned with the issue of problems in pregnancy. By this means I expand on the justification for the research presented.

In the attempt to challenge the medicalisation of childbirth, feminists have often promoted what are considered to be the more liberating models of natural childbirth and

new midwifery. These are also reviewed in Chapter Two and I challenge the idea that these alternatives do at the moment provide a more liberating childbirth context for women than the medical model. More fundamentally, I suggest that these alternative models accept in practice that problematic pregnancies must be subsumed within the medical model of childbirth. Thus, there is a lack of theorising as to how these experiences can be managed within a more empowering context.

Methodological considerations are presented in Chapter Three. It begins with the guiding assumption that underpinned the research: the need to engage in qualitative research framed within the premises of feminist social enquiry. I critically consider the possible implications of my own biography upon the research process, in particular the fact that I was myself a sufferer of pre-eclampsia. The sample is then considered and the methods used are reviewed. Finally, Chapter Three presents the ethical considerations and data analysis procedures.

There are four data chapters beginning at Chapter Four. The first considers women's initial perceptions of pregnancy and birth and the conditions of their emergence. It shows how many women held to a notion of 'normality'. This notion, however, was variable amongst the women and was not a clear representation of natural childbirth ideas. I then show how these early images were sustained, despite the seeming presence of evidence contradicting them. The data suggest in part how childbirth, as interpreted and lived out by women, accommodates concepts of risk emerging from the medical model.

Chapter Five explores women's experiences of pre-eclampsia and the medical response. It reveals the inter-relationships between the physical and emotional. The data fill a void in the existing literature by focussing on these experiences.

Chapter Six is called 'Unheard Voices', for that is what it presents: the experiences of women's husbands, partners and own mothers. When this research began, it was with the intention only to record women's own voices. It soon became clear that women's experiences were bound to those of their loved ones. This chapter presents an exploratory approach to understanding these voices and situating them within a wider form of theorising.

Disruptions to women's early images of pregnancy are revealed in the final data chapter, Chapter Seven. It explores the feelings of the women in the sample about medical intervention and their ideas for improvement, as well as some of the longer term consequences of their experience of pre-eclampsia. One objective of the research was to theorise attempts to provide an empowering context for women experiencing serious pregnancy complication. Their thoughts, presented here, are later taken as a basis for this.

Chapter Eight presents a discussion of the findings in the context of existing literature and in the light of the wider objectives of the research. In this chapter, I attempt to consider the relevance of my findings theoretically in relation to the existing feminist challenge.

Chapter Nine concludes the main text of the thesis. After briefly summarising the research, the chapter considers how my findings support some existing challenges to contemporary maternity policy. This chapter then identifies the recognised limitations of my research but also highlights its contribution and draws some overall conclusions about how the feminist challenge to medicalised childbirth might now be developed further. The aims and objectives of the research will now be identified, followed by a brief account of the nature of pre-eclampsia.

The general aim of this research is to reveal and explore women's experiences of the

pregnancy complication pre-eclampsia and its more specific objectives are as follows:

1. To consider the representation of pre-eclampsia within both medical and natural childbirth models as interpreted and experienced by women.
2. To explore women's changing understandings and ideals of pregnancy and birth.
3. To critically develop the feminist critique of the medicalisation of pregnancy.

The Nature of Pre-eclampsia

Pre-eclampsia is an illness unique to pregnancy. It can occur anytime after twenty weeks gestation and is considered to represent a problem with the placenta. Pre-eclampsia affects one in ten pregnancies, making it the commonest antenatal complication. One in 100 pregnancies will be affected seriously enough to cause organ problems for the mother, as well as growth and other problems for the baby (Action on Pre-eclampsia, 2006). According to the Confidential Enquiries into Maternal and Child Health (2004) during the years 2000-2002 14 women died from eclampsia (defined below) and pre-eclampsia.

Early in the illness, there may be no visible symptoms, with the evidence detectable only through routine screening tests. When it does become more visible the symptoms include swelling, vomiting, visual disturbances and pain below the ribs. There are three main characteristics of the condition. Firstly, hypertension indicates the circulatory problems caused by pre-eclampsia. Secondly, protein in the urine reveals developing kidney problems. Lastly, oedema, which refers to the retention of water in the body, is also linked to the problems affecting the kidneys. Eventually, pre-eclampsia affects all the

major organs in the body. Eclampsia is a serious complication of pre-eclampsia which can lead to death. This complication is characterised by fitting, present changes including brain haemorrhage and liver and heart necrosis (Roberts and Redman, 1993). Another serious complication, HELLP Syndrome can cause liver and kidney damage, uncontrollable bleeding and strokes (Action on Pre-eclampsia, 2006). In terms of the baby, the main danger is that as the placenta ceases to work effectively, oxygen and nutrients may be restricted, resulting in slower growth and possible oxygen starvation. The only way to cure pre-eclampsia is by delivery of the baby. Pre-eclampsia is, therefore, a major cause of prematurity with all its associated problems.

My own experience of pre-eclampsia now follows.

My experience

I suffered from serious pre-eclampsia twelve years ago. I now present what, through this study, I have asked others to provide: an account of a personal experience of the illness.

I had entered pregnancy excited but nervous at the prospect of becoming a mum. In terms of the physical side to pregnancy, everything was going fine. I read all I could lay my hands on, ate as well as possible, stopped drinking and generally considered myself as being perfectly capable of going through the process of pregnancy and birth with no major problems.

At twenty-eight weeks I began to develop a morbid sense of impending doom. Those around me shrugged it off as the nerves of a prospective first time mum. Despite such reassurance, I knew something was wrong, despite having a week earlier attended a routine

clinic which revealed no problems.

Over the following few days I became increasingly restless and nervous. I developed a pain on my right upper abdomen which Mum convinced me was simply a big baby laying on my ribs. I put on lots of weight and my hands and face swelled up. I would wake up in the night in pain, which was interpreted as indigestion, and felt an increasing need to go to the loo, but being unable to actually urinate. Despite common-sense reassurances that such problems were often experienced by mums-to-be, I did become increasingly uneasy. I phoned the emergency doctor who also reassured me that it was indigestion. I was advised to sit down and have a cup of tea, but to go to the doctor the next day to just check on everything.

As soon as the doctor saw me, she told me to lie down and not to move. Tests revealed extremely high blood pressure levels, four pluses of protein and, of course, severe oedema. An ambulance was sent for and I was rushed to hospital. I smiled at the paramedic for what I considered over-cautiousness, running the siren and watching me constantly. At this stage I was unaware that my kidneys had begun to fail, my liver was dangerously bloated, I had potential swelling on my brain, potential fluid on my lungs, blood clotting problems which could have meant I bled to death. I was at potential risk from fitting and lastly, but most importantly, the baby inside me had stopped thriving for several weeks. Her existence was killing me and I, in turn, was slowly killing her.

Once in hospital, I was attached to what seemed at the time to be numerous medical contraptions and I was eventually scanned. I was told that the baby was very small for dates and that my problems meant that she was being starved of both nutrition and oxygen. I was told that I was seriously ill and sometimes a decision had to be made that they had to put the life of the mother before the life of the child. My baby was going to be taken from

me and I would face possible death so that these problems - which even at this stage didn't feel as bad as they apparently were - would disappear. The word pre-eclampsia was mentioned but made no sense until I heard the word 'toxaemia'. At this point I felt much better. Mum had had that and this meant bed rest and a diet with no salt. I was convinced that they were exaggerating and that the worst case scenario was a lengthy and boring spell in hospital. That was the worst underestimation I have ever made in my life. I was told the baby would have a 70:30 chance of survival. I did not understand the direction of these odds. I did not ask.

I was told they were to induce me within a week at most. This would give them chance to inject me with the steroids which would improve the baby's lung function. But within the next five hours, I then was told that I was critically ill and that they could wait no longer. The baby had to be taken out of me; I was to have an emergency caesarean. At twenty-eight weeks I had never had the chance to attend parent craft sessions. I had no clue about the implications or the details of what was involved. I didn't ask. I simply remember 'dying' mentally and thinking that none of this could really be happening to me. I was told that a general anaesthetic was too dangerous and therefore I would need an epidural. I was so swollen that the practice of inserting the needle and the pain I felt was tremendous. I was then told that I would have to have a general anaesthetic. I thought that would kill me. They had already suggested that earlier. At this point, I must have gone into complete shock. My whole body began to shake from head to foot violently. I was told this was normal for someone in my situation. I remember every detail of the section. I remember the severe pain of it, convincing myself that it must be psychosomatic, only to be told afterwards that the epidural had not been as effective as it should have been. I remember the transporter incubator and the paediatric team waiting to whisk the baby off to some other hospital. I remember getting a brief glimpse of the baby before she was taken away, not to be seen for another four days. I was lucky in that, despite weighing just two pounds

and having severe lung problems, it was decided that the hospital could cope with her. She was ventilated for two weeks and remained oxygen-dependent for two and half months.

I was shown pictures of her and family and staff kept telling me how lovely she was. I, however, was still deemed too ill to face the trauma of seeing her. This did not matter to me. I had mentally closed myself down from her. She was going to die and I could not handle that. I would rather pretend she did not exist, that she had already died. She wasn't even like a 'proper' baby. She couldn't breathe on her own, had no ear lobes, was transparent, and even her brain was underdeveloped to such a degree that the slightest pressure on it could have caused bleeding. She was not going to live. Nobody seemed that bothered anyway. They simply brought a machine to express breast milk for when she might be able to feed from it. I was taken to a post natal ward which was coloured with cards and balloons and other 'well done' paraphernalia for more successful mothers. Babies would cry and be fed, bathed and cuddled and I did not even know the location of mine.

At the end of day four, I was wheeled down to see her. I will never forget the moment I saw her. Whatever horrors I had been expecting, it was nothing compared to the reality. It was worse, maybe simply because now the whole thing was real. She seemed as small as a bird. Wires and loud-sounding machines surrounded her. I could hardly see her tiny body. I dared not touch her in case I broke her. I remember just sitting, tears pouring from my eyes, but making no sound. The mental pain was indescribable and is beyond what words can suggest. The physical pain I was suffering at this point was describable. The epidural had gone wrong and I was left with a large gap in my spinal fluid. The consequences were that for a week I couldn't move my head, let alone any other part of my body, without sweating with pain. Still, this was the least of my worries. I sat by her all day and all night for three months. It seemed ludicrous to think of leaving such a small vulnerable little

thing. When my baby died, I would be there for her. I was discharged from hospital after ten days but never actually returned home. During this period of hospitalisation, she had numerous blood transfusions, scans, and bouts of pneumonia amongst other things. At three months, she weighed just over four pounds. It was not for another three months that I managed to see my consultant about what had happened. I got very little from him and eventually came across Action on Pre-eclampsia (APEC), a charitable organisation, which supplied me with the information that I had needed, including symptoms. Eventually, I became, for a period of two years, a Local Contact for this charity. I have been told that I am at high risk of getting the disease again and would need to be hospitalised at about twenty-six weeks with any further pregnancy. The nature of the section carried out means I can only be cut once more and cannot carry past thirty-two weeks. Generally, the doctors have advised me not to have more children. I have asked about my internal organs and whether they may have been damaged permanently. I was told that they did not think so, but, that if I did decide to have my once only go at becoming pregnant, it would then be that I would be scanned.

I had played my pregnancy by the book and it was still a disaster. For years, I felt that the emotional and physical effects were a result of my ignorance and inability to demand the support that I needed. I came to believe, however, that maybe the books were 'wrong' and maybe the context within which women like myself are plunged, does not do much to encourage such assertiveness. My voice and that of others who have suffered serious complications in pregnancy have been largely neglected in the feminist challenge to medicalised childbirth. My research has been an attempt to begin the process of remedying this.

Chapter Two

Problematic Pregnancies in a Problematic Literature

This chapter critically explores some of the most prominent feminist challenges to medicalised childbirth. My central question is the extent to which these contributions, not only *recognise* the lived reality of women like me and those who took part in my research, but also provide a suitable framework within which to *understand* and improve such experiences. The contributions considered are primarily, but not always, British and American; they are mainly drawn from sociological, feminist and anthropological literature. The feminist challenge to medicalised childbirth is one manifested, not only in theoretical ideals of liberated childbirth, but in ideas and practices of feminist inspired childbirth educators and midwives. It is expressed by those who claim to have identified more woman-centred models of childbirth. These ideas are also considered critically. Again, my basic question is the extent to which the alternatives promoted are meaningful to the needs and experiences of women whose pregnancies become problematised through pre-eclampsia.

My intention is to demonstrate a fundamental limitation in classical feminist challenges to medicalisation. This weakness is the tendency to marginalise the experiences of women who suffer serious pregnancy and birth complications. Basing the challenge on the promotion of 'normality' renders such women and their experiences invisible. Furthermore, this chapter will also consider some empirical research into women's experiences of pregnancy complicated in various ways and I will argue that an opportunity has been missed by the various contributors to develop the feminist critique of medicalised

childbirth. In this chapter I will also suggest the improbability of the promoted alternative models of childbirth to meet their needs. The chapter reveals the need to explore the experiences of women with serious pregnancy complications so that such experiences can be integrated into a developed critique of medicalised childbirth.

Feminist concern with medicalised childbirth did not emerge strongly until the 1970s. Oakley (1979a) explains this lack of interest in terms of the emphasis instead placed upon women freeing themselves from motherhood as part of a political strategy to increase women's participation in the non-domestic sphere. In the late 1970s Sally Macintyre (1977) published in the UK a review of existing sociological research issues pertaining to the management of childbirth. She noted the debate and controversy that had emerged in the years prior to her article and her bibliography testifies to the scant feminist critique in both the UK and America. However, by the 1990s this literature focused upon critically investigating and theorising the cause and consequences of medicalising childbirth largely petered out. It might be suggested that one reason for this in the UK was the development of maternity policy which seemed to have largely met many of the feminist demands in terms of improved care. The past five years, however, have seen the slow emergence again of feminist literature concerning pregnancy and childbirth. This has ranged from sociological concerns previously neglected (Thomas, 2003, 2004), feminist psychologists' focus on the failure of contemporary childbirth policy to secure true woman-centered control (Baker *et al*, 2005), through to literature for midwives reasserting the relationship between midwifery work, the needs of women and, therefore, the concerns of feminism (Stewart, 2004). Popular American feminist writer Naomi Wolf's (2002) account of the 'misconceptions' of pregnancy and motherhood further demonstrates this re-emergence of critical commentary. The past thirty-five years, therefore, forms the main time frame for the literature considered in this chapter.

The chapter initially considers the historical development of medicalised childbirth. I then locate the feminist critique within wider sociological concerns regarding medicalisation and the limitations of the medical model of illness. The second section of the chapter then specifically considers academic feminist accounts of medicalised childbirth. These include, in America, the early critical work of Haire (1978), the anthropological commentary of Martin (1992), the more contemporary sociological critiques of Rothman (1982, 1986) and Kahn (1995). In the UK, feminist contributions include Cartwright's (1979) critical analysis of induction, through to the many writings of Oakley (1979a, 1979b, 1980, 1984, 1986 and a collection of essays concerning women, medicine and health, 1993a). Some examples of empirical work into the experiences of women whose pregnancies and birth are complicated due to miscarriage or stillbirth (Lovell, 1983; Layne, 1997), disability (Thomas, C. 1997; Lipson and Rogers, 2000) or chronic and emerging illnesses (Thomas, H. 2003, 2004; Lawson and Rajaram, 1994) are also critically considered.

Feminist inspired childbirth educational writings are dominated by Kitzinger (1984, 1992) in the UK and Arms (1994) in America, with feminist inspired midwifery writings in the UK being dominated, in particular, by Kirkham (1986). Much of the feminist academic, midwifery and educational literature on childbirth cement feminism to the model of 'new midwifery' and the concerns of 'natural childbirth'. As apparently alternative models to that of the medical model, the promotion of these two in attempts to provide more empowering care contexts is unsurprising. Some, however, have been critical of this supposed close alliance. This debate is considered through a review of the related literature in section three and I show how the need to challenge the 'alliance' is also revealed when considering problematic pregnancies.

My analysis of the literature highlights the need for greater empirical research into women's experiences of problematic pregnancies. It also, however, begins to situate the concept of 'risk' as a key to understanding such experiences. Curiously, the sociology of risk is all but absent in considerations of pregnancy. This is surprising since the historical development of medicalised pregnancy and childbirth was premised on a redefinition of these reproductive processes as risky. This chapter will therefore briefly demonstrate and comment on this absence. More generally, therefore, it will justify a call for a return to a theoretical engagement in pregnancy and childbirth as crucial sites for sociological consideration where risk needs to come to the fore.

Medicalised Childbirth: A Brief History

The expansion of medicine into various spheres of social life in Western societies was a trend focused upon, by sociologists, in the 1970s. The medicalisation process has been associated with increasing social control (Szasz, 1974; Zola, 1972; Enrenreich and Enrenreich 1978; Foucault, 1971). Feminists have also described the medicalisation of female 'troubles' and have likewise related it to the increasing social control of women. Riessman (1992) and Miles (1991), provide an overview of the medicalisation of aspects of women's lives including menstruation, physical appearance, mental well-being and childbirth. With respect to the latter, attempts have been made to understand the historical, social and political processes which defined a trend whereby this aspect of women's lives would gradually be transformed from a 'natural' event, assisted by local women within the community, to a 'medical event' with inherent 'risks', which require control by a male dominated medical profession.

The history of the medicalisation of childbirth can be traced, from the dominance of

women lay healers in the community, through to the expansion of medicine as a male profession which developed a concern and eventual dominance over, firstly, 'abnormal childbirth' and later, pregnancy and childbirth generally (Arney, 1982; Donnison, 1977). The former was made possible as the emerging male medical profession developed the means and secured the sole right to use obstetric tools (primarily forceps) to intervene in difficult labour. 'Strategies of closure', (Witz, 1992), enabled men to dominate obstetrics and the distinction between 'normal' and 'abnormal' childbirth became institutionalised in a gendered division of labour. The lay midwife soon became attacked as part of a wider assault upon the growing independence of women and was evidenced in '...witch hunts, legal decrees of exclusivity and persecutions' (Finkelstein, 1990, p. 17). The eventual dominance of obstetrics over birth and pregnancy itself developed through a re-conceptualisation of the birth process as potentially pathological. The history is one characterised by rivalries, not only between medical men and female birth assistants (Oakley, 1976; Donnison, 1977), but also between the largely working class 'handywomen' and the emerging middle class professional midwives; the success of the latter dependent upon the marginalisation and eventual eradication of the former (Leap and Hunter, 1993). Indeed, the success of a growing professional midwifery would also depend upon an apparent acceptance of the supposed ultimate technical superiority of 'medical men', especially with respect to 'abnormal births'. This would eventually become reflected, not only in a largely gendered and unequal medical division of labour, but also in a process whereby medical men would extend this 'technical superiority' into the early identification of pathology, therefore enabling them to blur the distinction between 'normal' and 'abnormal' and claim ascendancy over the process of pregnancy and childbirth per se: medical surveillance and increasing obstetric intervention being the wider legitimated consequences.

The medicalisation of pregnancy and childbirth meant that these processes became

interpreted within the terms of Western medicine's dominant paradigm: biomedicine. Biomedicine can be understood via some of its basic assumptions. These assumptions have been criticised and such challenges have become mirrored in feminist analyses of medical conceptualisations of and practices around reproduction.

Firstly, the paradigm assumes that it is possible and indeed desirable that the mind and the body should be treated as completely separate. A general criticism of biomedicine is its failure to conceptualise and therefore treat patients as whole persons with social and psychological, rather than just biological, dimensions. Rather, the mind-body dualism inherent in the paradigm encourages a conception of the patient as a physical entity subject to 'maintenance' and 'cure'. Feminist critiques of modern maternity care suggest its failure to recognise that 'successful outcome' must be considered in terms wider than mortality rates. (1993d), for example, writes of the need to recognise the importance of promoting 'health' in its fullest sense; that is, giving recognition to social and psychological criteria.

Secondly, the biomedical model assumes that, like a machine, the body can be 'repaired' and that the role of the doctor is considered as akin to an engineer, utilising various technological means of intervention. That this is the most effective means of responding to illness has been subject to criticism. The link between medical interventions and the decline in mortality and morbidity rates has proven problematic. The often cited example of the work of McKeown (1979), illustrates such a challenge. His research demonstrated that, rather than medical interventions being responsible for the decline in contagious diseases, the most significant factors were improved hygiene, nutrition and patterns of reproduction. The supposed superiority of medicine has also been challenged by Illich (1976), who argues that, rather than always positively contributing to an individual's physical and psychological well-being, modern medicine can prove detrimental; hence his not unfamiliar concepts of 'medical', 'social' and 'cultural'

'iatrogenesis'. The effectiveness and potential detrimental impact of biomedicine's interventions during pregnancy and childbirth is a major area of concern amongst feminist commentators.

A third assumption is that the most appropriate response to disease and illness is technological intervention; the role of social factors in explaining illness is marginalised. Instead, biological changes are assumed to hold greater explanatory power therefore presupposing the superiority of biomedicine in dealing with illness (Nettleton, 1995; Scambler, 1991; Jones, 1994). Annandale (1998) isolates another characteristic of biomedicine, which is its claim to scientific neutrality. The medical paradigm assumes that medicine can be objective and value free in that individuals' are treated and dealt with solely on the basis of their medical needs rather than any social or moral criteria. These assumptions have framed the practice of medicine, including obstetrics, and hence individuals' experiences of it.

A fourth fundamental critique of biomedicine is the assumption that medicine is value free and objective. Annandale cites the example of AIDS to illustrate that "...medicine relies in its operation upon general cultural ideas in society" (1998, p.7). The idea that modern medicine, far from being 'scientifically neutral', in fact operates to reflect and reproduce dominant ideas, is again of significance to feminist analyses of maternity care, which suggest that its generalisation to pregnancy and childbirth has served to reinforce patriarchal ideology.

The Feminist Challenge: Themes and Directions

As well as criticisms of the medical model, the literature relates improvements in

maternity care with the promotion of midwifery and the natural childbirth model. This is critically considered in a later section of this chapter. Before that, the criticisms of the medical model, as expressed in existing feminist contributions, will be developed through a consideration of specific contributions. The language used by the early contributors testifies to the critical perspective adopted. Women's wombs are 'captured' (Oakley, 1984), women themselves 'confined' (Oakley, 1980), the 'dignity of labour' undermined (Cartwright, 1979), and the reality of childbirth 'warped' (Haire, 1978). In part this was understood in terms of the 'miseducation' of obstetricians (Sculley, 1980). My central concern throughout is the extent to which these critical contributions provide for an understanding of the experiences of women with serious complications of pregnancy and birth. Without this, the feminist challenge remains a partial one.

In writing about the ways in which biomedicine has dominated the understanding and care of childbearing women, feminists have used different phrases. Whilst some simply refer to biomedicine, others write of the 'medical paradigm of reproduction' or the 'medical model', (Oakley, 1979b, 1980). The 'biomechanical model' is also used by those keen to emphasise that aspect of the model that views women as 'machines' to be 'repaired', though the continual relevance of this metaphor is contested by Martin (1992), who claims that work production analogies are more significant. Rothman (1982) writes simply of the medical model. For the purposes of consistency, unless engaging precisely with the issue of changing conceptions of childbearing and therefore terminology, when referring to the way in which biomedicine defines and deals with childbearing women, I, too, will use the term the 'medical model'.

When I refer to the feminist challenge I am essentially referring to that body of work which, though having different forms of emphasis, amounts to a collective challenge. Combining the feminist literature on medicalised childbirth, I suggest that this has been

characterised by three major critical themes. Firstly, I consider the contributions which have identified the ways in which the medical model of childbirth has been unable to fully accommodate the needs of women. Secondly, I consider that work which has focused on the ways in which medical intervention has produced negative consequences upon women physically and emotionally. Thirdly, I identify and discuss work which reveals how the construction of childbirth reflects the nature of our society, with feminists concerned with understanding how medicalised conceptions reflect patriarchy.

A Narrow Conception of Women and their Needs

Feminists have suggested that the medical model of childbirth contains a conceptualisation of women which is narrow and therefore unable to fully embrace women's holistic selves and needs. In part this reflects the Cartesian duality between body and mind that characterises the medical model. According to Oakley (1980), for example, within medical conceptions of childbirth, or what she refers to as the 'medical paradigm of reproduction', women are conceived as mere 'pregnant patients', an important concept used to describe the conception of pregnant women as essentially devoid of wider needs and concerns. It is a term I refer to frequently throughout this thesis. The reality of most women's lives is one where their 'patienthood' remains but one of many statuses (wife, existing mother, employee etc). In *Women Confined* (1980), Oakley attempts to develop a sociology of childbirth in recognition of hitherto limited accounts of reproduction. Her critique in this book and her attempt to develop an alternative, essentially feminist sociological, understanding is largely based upon her research findings from her *Transition to Motherhood* study which investigated sixty-six women's experiences from conception through to five months postpartum. The findings are documented in detail in *From Here to Maternity* (1979a). One theme emerging from these two books is the conflict that emerges

between women and obstetricians as the reality of their lives make problematic women's status as 'pregnant patients'. She describes various instances whereby a woman's attempt to communicate the significance of her other obligations and responsibilities, (e.g. the need to continue with domestic chores despite being advised to take complete rest), have been met with hostility or simple apathy. According to Oakley '...the intrusion of 'personal' considerations into medical decision making transgresses the prevailing norm of reproduction as a medical process' (1980, p. 31).

Graham and Oakley, (1981) drawing upon their own separate research projects concerned with pregnancy, birth and the early postnatal period, equally identify the 'isolated patient' versus the 'whole person' approaches as an instance of the conflicting medical and maternal respectively. Another example of the contrasts includes perceiving reproduction as a medical subject as compared with a natural process. In the medical 'frame of reference', success is equated with low levels of perinatal and maternal mortality. According to Graham and Oakley, this assumption is very much at odds with the 'maternal perspective', which views success in a much more holistic way. Therefore, a successful personal experience in relation to pregnancy, birth, the later mother-child relationship and the integration of motherhood with the rest of a woman's life, is considered as significant. Likewise, Doyal (1995) also recounts how the perceptions of childbirth held by most doctors and that held by most women are at variance. Whilst women consider medical care as something 'on hand', just in case it becomes needed, most doctors operate on the assumption of 'risk' to all women which, as Doyal points out, can result in unnecessary intervention.

Later, in her essay on the relationship between consumerism and the development of perinatal health care, Oakley (1993f) again argues that 'success' has to be measured more widely. She articulates a concern with promoting women's social and psychological well-

being rather than just physical health and suggests that the ‘...impact of current obstetric practices on women’s social and psychological health... should be considered as one of the ...indices of good care’ (p. 60). She suggests that ‘...happiness is an important way of measuring the effectiveness of obstetric care’ (p.61).

All of these feminist contributions highlight the failure of the medical model of childbirth to embrace the social and emotional needs of women. Recent work confirms this with, for example Baker *et al* (2005) revealing how the psychological dimensions of maternity care in the UK continue to be marginalised. Much earlier, in America, Scully’s (1980) research into the training experiences of obstetricians in two teaching hospitals, revealed the processes whereby the attitudes and skills of these professionals did not match the care needs of women. Based on a three year observational study, as well as an analysis of training texts, her book details the history of medical education, the impact of sexism upon it and the resultant inability to provide a care context that truly meets the needs of women. She is specifically concerned with the issue of unnecessary surgery and suggests it can be understood by the emphasis placed upon ‘medical judgement’ and ‘surgical skills’ in the training received to the detriment of learning to ‘care’ and ‘support’. This compares with the focus of midwifery upon assisting women in a natural process. Scully suggests that women’s negative experiences are also in part created through male practitioners who ‘...because they can not experience the problems they treat, tend to trivialise or misinterpret the significance these problems hold for women’ (p.93). The focus of Scully’s criticism is on the issue of unnecessary interventions though she recognises the significance of intervention in emergencies.

‘Obstetrical interventions have a place in complicated labours and deliveries...’ (p.38)

Her comment occurs only in passing however, and she provides no sustained analysis

of such women's experiences.

The work considered here has shown the way in which childbearing women are conceptualised in a way which conflicts with the lived reality of their lives. This is partly evidenced in the competing perceptions of the pregnancy process held by women and obstetricians, for example. Yet, some questions remain. For example, do women experiencing serious complications develop and continue to hold to what Graham and Oakley (1981) referred to as a maternal frame of reference? Such a question has not before been asked and therefore not yet been answered.

Iatrogenic Consequences

The levels of supervision and intervention consequential upon defining pregnancy and birth as medical events have received criticism from early feminist work on the basis that they have often proved detrimental to women. The early American contribution of Haire (1978) highlighted the risk of physical damages sometimes associated with obstetric medications, in particular neurological impairments. Whilst not all interventions negatively impact on infant mortality and morbidity, she condemned the generalised use of things like routine electrical foetal monitoring and chemical stimulation of pregnancy, arguing that they reduced neither such morbidity nor mortality. With this perspective, the interventions therefore represent a distorting of normal childbirth into a pathological event. Like Scully, her critique is focused on the generalisation of obstetric procedures to normal pregnancies rather than the social organisation of those procedures when required in pregnancy complications. In the UK, Cartwright (1979) conducted a large questionnaire survey on women's experiences of induction, together with questionnaires and interviews of midwives and obstetricians' views and experiences. At the time this was to be the first such

large scale assessment of these experiences. Her findings questioned the clinical effectiveness of inductions and revealed evidence of the negative experience and perception of the procedure.

‘...with the preference of the great majority of childbearing women for not being induced, the lack of evidence about the circumstances in which the benefits of induction outweigh the disadvantages, and the costs and hazards of the procedure, adds to a clear indictment of the routine use of the procedure after the expected date of delivery’ (p.160)

Though Cartwright did not directly engage in an analysis of problematic pregnancies and their significance in terms of women-centred maternity services, in relation to the increasingly critical perspective towards obstetrical care, she wrote of the need for more ‘co-operation and more energies towards changing services’ as compared to rejecting them and ‘vilifying’ doctors (p.164). It is in relation to this perspective, and her suggestion of the role of midwives in facilitating information exchange, that perhaps possibilities are provided for improving the conditions of women whose pregnancies necessitate intervention. Unfortunately, Cartwright’s emphasis on the problem of unnecessary intervention prevented her from engaging in this.

Oakley’s (1979a) research also revealed some of the negative effects of obstetrical intervention making the transition to motherhood difficult. She assessed sixty-six mothers’ reactions to birth in terms of six outcomes: presence or otherwise of postnatal blues during hospital stay; depressed mood; depression in the first five months; levels of anxiety; overall satisfaction with motherhood and mothers feelings towards their babies. These were then analysed in terms of their association with several factors *including* instrumental delivery, epidural block and levels of technology. Oakley found a link between depression and medium and high levels of technology and feelings of low control during labour and

postpartum blues with instrumental delivery and epidural analgesia. Whilst Oakley's sample size was relatively small to make a definitive link, later research bore out these earlier criticisms. Mutryn reviewed the research literature into the relationship between obstetrical interventions and the psychosocial impact upon the family, as well as women themselves (Mutryn, 1993). Her conclusion was that the effects were 'largely adverse' (p.1278). Research indicating the detrimental impact of obstetric intervention upon women's psychological well-being is also cited by Doyal (1995). She dramatically illustrates the distress caused by the consequential loss of autonomy by quoting the feelings of one woman:

'I felt my labour had been taken over by strangers and machines ...any fragile confidence I may have had in my body's ability to handle birth had vanished.'

(Doyal, 1995, p.124)

Despite such negative consequences, Doyal concedes the legitimate use of obstetric technology, stating that there are '...clearly circumstances in which such techniques can be valuable' (1995, p. 126). However, a focused concern on preventing such distress amongst women who have no option but to be subject to interventionist technology is not followed through.

The conclusion, however, that interventions can produce negative social and psychological effects is complicated by research suggesting that women's experiences of maternity care depend upon their initial conceptualisation of the pregnancy and birth process (Nelson, 1983, Zadoroznyj, 1999). Nelson, for example, showed how the concern of working class women was to have their pain controlled, rather than to seek control over the birth process itself in the way feminists were advocating.

In 1999, Fox and Worts attempted to reconcile what they saw as a difference between feminist critiques of medicalisation and women's actual experiences of accepting medical intervention. They did this by focusing on the micro level of women's lives and in particular in relation to levels of social support. Women welcomed pain intervention when they had poor social support. Their contribution is useful in isolating the apparent contradiction and in focusing attention of the lived experiences of women in relation to their specific social situation. However, it does not help us understand the way in which serious complications of birth constitute such a social context; a context within which women may have little choice but to accept high levels of intervention.

The Social Context of Medicalised Childbirth

The nature of a particular culture influences the way in which childbirth comes to be constructed and responded to. This construction can be identified in the text and images available to pregnant women and their carers. Graham's (1977) analysis of the history of antenatal literature, and the inherent contradiction between an ideology of pregnancy as normal and pregnancy as risky, was an early attempt to demonstrate this. In 1982, Katona analysed childbirth literature to reveal the assumption behind approaches to childbirth education. Both of these showed how the language and pictures used served to integrate a seemingly alternative ideology of pregnancy as natural and normal within, what remained the dominant medical model of pregnancy. In her historical analysis of the establishment of antenatal care in Britain, Oakley (1984) suggests that it was only made possible by the gradual dominance of an ideology which rendered women's 'personal knowledge of reproduction' (and especially that developed via community relationships) of limited relevance. Again, Oakley situates this devaluation of women's knowledge in the context of

the general social control of women.

The focus on how the construction and response of childbirth reflects the wider (patriarchal) culture and serves to regulate and control women has more recently been further underlined in Marshall and Wollett's work (2000). Their analysis of popular texts for pregnant women in the later 1980s and throughout the 1990s led them to conclude that, rather than being progressive, both medicalised and 'women-centred' literature achieved the social control of women through the promotion of self regulation and the normalisation of technological birth management. However, it is with the work of Martin (1992) and Kahn (1995) that we find examples of detailed expositions of the relationship between the literature and teaching of birth and the social control of women within patriarchal society.

Drawing upon her own childbirth and mothering experiences and an analysis of the 'language of birth' expressed in obstetric texts, Kahn (1995) demonstrates the relationship between the 'words' and medical birth practices in America. She uses words such as 'attack', 'appropriate' and 'neglect' to describe the effect of these texts in subverting the power that women actually yield in childbirth. Kahn seeks 'new languages of birth' that seek to empower women in alternative texts like that of the Boston Women's Health Book Collective. Autobiography infuses this work and directs her accounts. Her perception of her own pregnancy was heavily influenced by the work of Kitzinger (1972) which promoted a 'psycho-sexual' approach to childbirth, emphasising its joyous and passionate nature. Kahn describes her positive experience of childbirth where she learnt the power of birthing. '...I could do things that were fundamental to human existence' (p.38) and her subsequent analysis of the language of birth and its relationship to patriarchy is directed towards liberated women from highly medicalised childbirth practices so that all may embrace this power of birth.

Martin's (1992) work is based on interviews and an analysis of childbirth texts. She demonstrates how 'metaphors of production' inform the description and treatment of women's bodies. For example, like factory labour, a woman's labour is divided into many stages. The language of some of the texts suggests that intervention is akin to increasing productivity. Like the foreman, the doctor 'manages' the process. In doing so, women are effectively disempowered. Martin writes of the consequences in terms of separation of self and body, especially with high levels of intervention. Women feel literally objectified with their 'being' marginalised as their body is treated. Martin seeks a new language which contests this process. The ones considered are imbued with notions of nature and spirituality and void of all medical interventions, making them inapplicable to women who need such support. The failure of Martin to explore the experiences of women whose pregnancies necessitate medical technology and skills is no surprise given her own confession of '...extol [ing] unmedicated birthing' (p.xvi). Her introduction to the 1992 edition of *The Woman in the Body* includes a critical reflection on her failure to really capture the complexity of women's pregnancy and childbirth experiences. In relation to technologies of birth, whilst she admits to not embracing women who '...value and desire highly technological and surgical births' (p.xvii), there is no recognition of ignoring women who are subject to such births, not because they 'desire' them but because their and their babies lives are at risk without them.

Rothman (1982) also seeks to demonstrate the way in which the construction of childbirth according to the medical model reflects patriarchy. She isolates two ideological dimensions to the medical model, those of technology and patriarchy. Whilst the body as a machine notion might emerge from an ideology of technology, the reason for women's bodies (machines) being constructed as more problematic and in need of control stems from patriarchal ideology which suggests the male body as the norm. 'From that viewpoint, reproductive processes are stresses on the system and thus disease like' (1982,

p.37). In terms of my own interest in the care of women with serious pregnancy complications, I found Rothman's early words in this book disappointing. She begins by asserting the fact that she had two choices:

'...bringing personal autonomy and social support into the hospital or bringing safety home. As a sociologist I thought the former was impossible. I set about researching the latter' (p.11)

I am interested in the former, for all women and those with pregnancy complications. However, after providing a critical account of the politics of maternity care and detailing distinctions between, what she refers to as the 'medical model' and that of midwifery, her epilogue raises the issue of the role of the midwife in complications requiring intervention. Whilst claiming that any conclusions are difficult, so long as midwives assume responsibility for normality rather than pathology, she suggests their role as 'case keepers' throughout. Unfortunately, there is little further detailed consideration.

The social context within which childbirth has been constructed and responded to includes social assumptions regarding 'what a mother is supposed to do and feel' which will influence women's experiences and responses to medical management. In relation to childbirth, Oakley (1993d) suggests that their subordination is reflected in the paradox facing childbearing women: '...that, although the *most* socially important activity, it is also rendered the *least* important, as cultural ideologies and practices enforce women's marginalisation' (p.99). In an earlier work Oakley (1980) suggests that the subordinate position of women is a significant factor in understanding the association between medical intervention and depression. From the experience of their subordinate group status, women approach childbirth with a lack of confidence in their ability to control it; confirmed by the very real uncontrollability of childbirth. Medicalisation is significant at

this point because what doctors do in the name of medical control reinforces the response of learnt feminine helplessness to life crises. Therefore, medical control and intervention can be understood as reinforcing women's sense of helplessness and therefore increasing the likelihood of depression. As Oakley argues '...both medical control and subordinate group status militate against self determination and encourage helplessness' (1980, p.272). Evidence of the importance of women's position in the wider social context is suggested by Oakley's (1979a) research which suggested that women who in some way deviate from the 'feminine ideal' are more able to 'cope' with the crises of first time motherhood than those who conform to the ideological ideal. It seems therefore that any consideration of the influence of medicalisation upon the experiences of childbearing women must be understood in the context of a society in which the construction of womanhood and motherhood may prove oppressive to women.

Oakley's writings on childbirth in Britain have undoubtedly contributed to the feminist challenge to medical practices that deviate from most women's needs and often create iatrogenic consequences. In *From Here to Maternity* (1979a), the starting point that seems to fuel her critique is laid bare.

'Practices that undoubtedly benefit a minority of women are applied unthinkingly to the majority who do not need them' (p.18)

She is, of course, correct. However, what of this 'minority of women'? As with previous contributors, conceptualising the problem in terms of the unnecessary generalisation of medical supervision and intervention has left under-analysed the need to understand and seek improvements in the care experiences of those women for whom such medical care is a basic need without lending ideological justification to a system of care which disempowers women. Problematic pregnancies are not ignored *per se*. As we have

seen in this chapter, contributors made mention of pregnancies which become complicated. There is a partial acknowledgement of such women and the benefits accrued by medical interventions. However, recognition alone does not amount to a developed framework providing for an analysis of how the experience of problematic pregnancy can be integrated into a more fully developed critique of medicalised childbirth. Furthermore, we will see shortly how the alternative models of maternity care promoted by the existing challenge cannot incorporate women with serious complications. There is a need therefore to step back and conduct focused research on women's experiences of pregnancy complications. A number of researchers have attempted to do this. The next section considers examples of empirical research concerned with such pregnancy experiences. It reflects upon their contribution in providing for an expanded feminist critique of medicalisation which does not marginalise problematic pregnancies.

The Terrain of Problematic Pregnancies

The terrain of empirical work on the experience of problematic pregnancy consists of four broad areas. Whilst limited in quantity, it is significant in revealing experiences too often marginalised. The first area of empirical research is that related to miscarriage and stillbirth (Lovell, 1983; Layne, 1997, 2003; Abboud and Liamputtong, 2005). The second area considers disabled women's experiences of pregnancy (Thomas, C. 1997; Lipson and Rogers, 2000) and the third concerns women with various pre-existing forms of chronic illness and illness developing throughout pregnancy (Corbin, 1987; Lawson and Rajaram, 1994; Thomas, H. 2003, 2004). It is possible to categorise a fourth area which consists of a variety of contributions concerned either with general issues relevant to women experiencing pregnancy complications or the psychological dimensions of such complications. There has also been some consideration of the general issue of women

experiencing hospitalisation because of pregnancy and childbirth (Kirk, 1994) and the experience of neonatal care (Reid, 1995). From a psychological perspective, the impact of pregnancy complications has been examined in relation to parental adaptation and bonding (for example, Dulude *et al*, 2000). These four areas will now be reviewed in turn.

Lovell's (1983) research into pregnancy loss focussed on the way in which professional responses were part of a process whereby mothers' and babies' identities were deconstructed. Thus, women's identity as 'mothers' and their babies' identity as 'proper babies' which should therefore be mourned, become undermined. Based upon semi-structured interviews with twenty-two women and interviews with staff in four hospitals, she found that miscarriage, stillbirth and perinatal loss resulted relatively abruptly in the loss of both 'mother' and 'patient' identity. She argues that health professionals need further training in dealing with these situations. Formal (e.g. funerals) and informal (information sharing) 'rituals' were explored as a potential aid. Lovell does not directly identify such experiences as a challenge to the existing feminist critique of medicalised childbirth. Her only mention of this challenge is in the final part of her discussion where she defends her call for better training in grief in the context of her awareness of being challenged for seemingly increasing the amount of medical supervision and intervention.

Layne (1997, 2003) more directly relates the experience of pregnancy loss to feminist analyses. She argues that feminist attempts to demedicalise pregnancy and birth have led to an overemphasis on 'happy outcomes' (1997, p.293) and attempts in her work to make deviations from such outcomes visible. Her research has focused upon groups dedicated to supporting women experiencing pregnancy loss. Layne argues that such research shows the negative consequences of feminist challenges to medicalised childbirth. Women are already subjected to a wall of silence which is then, she argues, reproduced through the failure of feminists to really engage with the issue. This failure is understood by Layne as

emerging from the fact of pregnancy loss contradicting two basic assumptions of the feminists: that childbirth is natural and joyous and that it is controllable by women themselves. Though Layne's work is based only on pregnancy loss, I share her criticism of many existing critiques of medicalised childbirth. Whether it is pregnancy loss or serious pregnancy complications, there is a need to break the silence so that the experiences of such women can be acknowledged and integrated into new visions of women-centred maternity care. Whilst Layne is critical of feminists, she does not seek to build further on this challenging insight, neither does she consider the possibility of others doing so.

Other contributions to the area of pregnancy loss have considered the experiences of specific social groups. For example, Abboud and Liamputtong (2005) considered the coping strategies of a group of six ethnic minority women who suffered a miscarriage and their partners. Resting and thinking about the future were some of the strategies adopted. Men focussed upon their partners as a way of coping and indeed women's husbands and partners were considered as the most important source of support. Abboud and Liamputtong also found that, for some women, the very experience of health care made the experience of miscarriage worse. They therefore identify the need for more sensitive practice and recognition of the importance of miscarriage as an event for both parents. Generally, their research identified no differences between their sample of ethnic minority women and that found by previous research on non minority groups of women. Understanding coping strategies and social support as dimensions of women's experience of miscarriage is important and may prove valuable in understanding these processes in relation to a range of pregnancy complications. However, this empirical literature does not seek to advance theoretical arguments on the need to develop the feminist critique of medicalised childbirth.

A second theme in the literature relating to problematic pregnancies is that concerned

with disability. Thomas, C. (1997) notes how the experiences of disabled women have been 'largely overlooked' (p.623) in studies on pregnancy and birth within sociology. Based upon semi-structured interviews with seventeen disabled women, Thomas comprehends their experiences primarily within, what she refers to as a 'disablist' framework. Thus, women's reproductive experiences are understood, not in terms of their physical impairment *per se*, but rather through 'disablist' attitudes and provision. The assumptions of health professionals, and sometimes significant others, subjects women with disabilities to a medical risk discourse with associated subjective consequences such as guilt. Furthermore, they experience greater pressure to prove themselves as 'good mothers' and experience advice and support which can often be unhelpful. Thomas's main concern, therefore, is with revealing the barriers which illustrate themes from the sociology of disability; in particular, disability as socially constructed as it is made visible in pregnancy and childbirth. The opportunity to explore the way in which these experiences reveal some of the limitations with existing analyses of maternity care is overlooked.

Lipson and Rogers' (2000) research is based upon the experiences of twelve disabled women. They link the women's experiences of pregnancy and birth to their pregnancy expectations, nature of available resources and health care organisation. The latter, they argue, is defined by a lack of understanding regarding the needs of disabled pregnant women and, as a consequence, a lack of effective organisation to meet such needs. For example, they found that there was an unnecessary use of high technology and insensitive care practices. Lipson and Rogers suggest various practical improvements including the training of professionals in disability awareness and improved communication and collaboration between various health professionals. Whilst Thomas's, C. (1997) paper explored disabled women's experiences in terms of the social construction of disability, Lipson and Rogers do not consider theoretical frameworks within which to comprehend their sample's experiences in any direct way. Undoubtedly, their research reveals

fundamental issues which need addressing and they rightly identify recommendations to improve the maternity care experience of disabled women. Like Thomas's contribution, however, the relationship between their findings and the wider feminist framework challenging medical dominance over childbirth, is not considered.

The third area of literature relating to problematic pregnancies is that concerned with women with chronic illness. Corbin's (1987) longitudinal research was based on twenty women whose various chronic illnesses, for example multiple sclerosis, complicated their pregnancies. Using interviews and observations she identifies the strategies through which the women managed the associated risks. Women 'assessed' the level of risk to their pregnancy by drawing upon a variety of sources of information. What Corbin refers to as 'balancing' describes their weighing up of various risk management possibilities. The women also worked jointly with health professionals to manage their risk. This she calls 'controlling'. These three strategies are collectively referred to as 'protective governing'. Corbin's research is of particular significance in identifying the experiences of women who enter pregnancy having to deal with risks that those without chronic illness do not. Understanding the ways in which women engage with these risks in an attempt to control them is valuable. As shown previously in this chapter, classical feminist critiques of medicalisation have based their challenge on a rejection of risk as a central concept around which to organise maternity care. For women with chronic illness, risk cannot be so marginalised and therefore to explore such experiences is a necessity to any developed critique of medicalised childbirth which does not marginalise such women. Whilst Corbin herself does not offer any suggestions for how this might be attained, her work provides a foundation for any such attempted development.

Both of Thomas's, H. (2003, 2004) papers in this area are based on a qualitative study of fifteen women. These women included those with pre-existing medical conditions as

well as those who developed a serious illness throughout their pregnancy. In her 2003 contribution, she shows how women respond and manage their dual careers as 'patients' with an illness and 'pregnant women'. Thomas usefully describes the processes whereby these two careers become ultimately untangled. For example, she shows how the end of the pregnancy marks that point in time when women with chronic illness regain a sense of control over the management of their condition. By contrast, for women with pregnancy induced complications, she argues that birth becomes that point in time when the career of 'ill woman' often ceases though some may be burdened with concerns about future pregnancies. Her 2004 paper focuses specifically on the postnatal experiences of such women and identifies the processes through which they try to regain a sense of normality, whether that is physical wellness or control over the management of their chronic condition. Her research identifies the lack of support available to such women during this time. Thomas suggests that this could be explained in terms of the general construction of the postnatal period. The birth period is established, by medical discourse, as a specific and significant point in women's pregnancy careers. By comparison, the postnatal period is considered as a 'follow on' to this important point and therefore is constructed as non-substantive. The result is less care and attention dedicated to it. Given the needs of women during this time who have experienced a complicated pregnancy, this construction of the postnatal period is particularly problematic. Illustrating the often unmet needs of such women she isolates an irony of medicalised childbirth in that:

'...having extended a medical model to normal childbirth and established the hospital as its organisational site, the needs of women with continuing medical problems can become lost amongst the normal, low risk majority population of maternity patients' (2004, p.86)

Thomas's work helps to rectify what she calls the 'surprising silence' (2004, p. 76) around the issue of pregnant ill women. She helpfully identifies the particular experiences of such women during pregnancy and suggests the usefulness of multi-career analysis in

understanding the ways in which they adopt dual careers as pregnant women and patients, as well as the processes through which these careers are disentangled. As shown earlier in this chapter, previous contributors have noted the way in which the medicalisation of childbirth constructs women as 'pregnant patients', robbing pregnancy of its natural status and infusing it with the assumption of illness. Thomas's contribution is to highlight the way in which for women with pregnancy complications, the separation of patienthood from pregnancy cannot so readily be achieved; it depends not upon the reconstruction of pregnancy as normal, but rather upon the lived reality of women's recovery from illness. Understanding women's experiences of problematic pregnancy through careers analysis locates this work within the sociology of health and illness literature. The significance, however, of such analysis in relation to the feminist corpus of work is less evident.

Lawson and Rajaram's (1994) work is perhaps the most directly comparable with the focus of this thesis, given its concentration on an illness developed throughout pregnancy: gestational diabetes. Lawson and Rajaram's research was based on interviews with seventeen women diagnosed with the condition. The significance of this contribution in relation to the research presented in this thesis partly lies with the similarities between gestational diabetes and pre-eclampsia. Both are defined only in relation to pregnancy, both may remain hidden without diagnostic mechanisms, because of their emerging nature throughout pregnancy, both may disrupt women's perception of the normality of their pregnancy and both tend to disappear after delivery. Such illnesses do in effect 'transform' women's pregnancies and despite the fact that of gestational diabetes ends with childbirth, Lawson and Rajaram explore the longer term psychosocial consequences of the condition. These include shock, guilt and fear. They found that the majority of women in their sample experienced a lack of autonomy and involvement in decision-making whilst hospitalised. They briefly relate this to the feminist critique of the unequal relationship between women and health professionals. Lawson and Rajaram's research is important in understanding the

subjective consequences and importance of patient-professional interaction in relation to women whose pregnancies are radically changed through the emergence of a pregnancy related serious illness. Their concept of a 'transformed pregnancy' is useful in capturing this. They argue that women's psychological states should be understood, less in terms of the disease *per se*, and more in terms of issues such as professional dominance in obstetrical care. As mentioned earlier, this latter point is linked by the authors to that aspect of the feminist critique which identifies the hierarchical relationship between women and health professionals. However, the argument remains a one paragraph underdeveloped point. The importance of gestational diabetes as an experience which cannot easily be encompassed within the classical feminist critique of medicalised childbirth because of the premise of normality which pervades it is not identified in any direct way. Instead, the need for further research is identified in areas including whether women face discrimination in work, for example, because of being categorised as 'high risk', and the significance of race and class in women's adaptation to gestational diabetes.

A fourth theme categorising the existing literature on problematic pregnancies is that which reveals some of the more general dimensions of women's experiences. The work of Reid *et al* (1995) considers the views of staff and parents involved in four Scottish neonatal intensive care units. The research revealed liberal policies regarding family involvement with the babies though the practical reflection of these policies was sometimes hampered by more negative staff views towards such involvement. For example, policies stated the need for parental involvement in the care of babies but sometimes members of staff were concerned about the risk of infection posed because of such practices. The authors make various recommendations including the need for all units to practice active parent involvement in the care of their, training for staff in communication and the opportunity to discuss concerns regarding unit policies. Women who suffer serious difficulties in pregnancy may have some encounter with neonatal care

and therefore any research identifying these issues is of relevance in understanding such experiences.

Kirk's (1994) research involved fifty women in one maternity hospital who were hospitalised for three days or more. She was concerned with identifying their needs and in particular the role that midwives might play in meeting these. Her findings showed the impact of their hospitalisation on their families, with a high number reporting behavioural problems in their children. Some women reported negative feelings towards their babies and/or themselves. There was a correlation between length of hospitalisation and levels of stress. Kirk considers the implications of these findings for midwifery practice. Midwives should provide a counselling role to women, perform the role of a facilitator of self-help groups and ensure that women's partners are fully informed. She proposes ward based parent-craft classes for hospitalised women run by midwives. Ways of tackling boredom and the reduction in institutionalised processes, like ward appearance and clothing, are also considered. Kirk's suggestions are based on the contention that pregnant hospitalised women are different from most other patients, insofar as they often do not feel ill and they have to deal with the stressors of both pregnancy and hospitalisation. The significance of this research and her suggestions is that they are geared towards an attempt to provide an individualised form of care within the confines of hospital and the constraints of obstetrical complications. The contribution of Kirk's work is that it makes some practical suggestions, based upon women's views and through a promotion of the midwifery role, of improving the conditions of women whose pregnancies may be seriously complicated. Unfortunately, her work remains largely non theoretical and there is no reflection on how such practical changes relate to the broader feminist challenge. Nevertheless, both Kirk's work and that of Reid *et al* (1995) are examples of helpful and practical research which may aid the development of a system of care which meets the needs of women with serious pregnancy complications.

From a psychological perspective, problematic pregnancies are of interest partly because of their possible impact upon the parental adaptation and bonding processes. For example, Dulude *et al* (2000) compared sixty-eight high risk and fifty-nine low risk pregnancy couples. Their research, however, only moderately supported the idea that high risk status would impact upon the adaptation process. Research which examines the longer term impact of pregnancy complications upon, not just women, but their relationships with their children is significant. Dulude *et al's* research, however, only considered high risk pregnancies which resulted in full term babies and therefore cannot be generalised to instances whereby babies are very premature or 'small for dates', as is often the result of severe pre-eclampsia.

The fact that problematic pregnancies have not been entirely neglected as an area of research is shown by the empirical literature considered above. This work has undoubtedly contributed to our understanding of the social and emotional dimensions of such experiences and the limitations in maternity care often associated with it. However, I suggest that such empirical work fails to develop a sustained theoretical perspective regarding the feminist critique of medicalised childbirth. It is neither clearly used to support the challenge or to dispute it. In the case of Thomas, H. (2003, 2004) and Layne (1997, 2003), the silence regarding problems in pregnancy within sociological work on reproduction is directly criticised. However, an attempt to integrate these experiences into a developed feminist framework to challenge medical control over pregnancy is absent. The work commonly associated with the classic feminist critique, reviewed earlier in this chapter, marginalises the experience of problematic pregnancies, not through a complete disregard, but rather through a partial acknowledgement which is not integrated into the critique of medicalised childbirth. It can be argued, therefore, that neither the empirical work on problematic pregnancies nor the classic feminist critique completely ignores the

issue of complications in pregnancy. Nevertheless, the relevance of women's experiences of these pregnancies for the existing critical framework has not been drawn out. It can thus be argued that the result is an overall problematic literature regarding problematic pregnancies.

The Feminist Challenge: Alternative Models of Childbirth

The feminist challenge to medicalised childbirth is one defined by, not only theoretical concerns, but practical considerations regarding maternity care for childbearing women. The attempt to seek alternative models of childbirth that empower rather than subvert women's control has led many to promote the model of care encompassed within what has become known as the new midwifery. The premises of natural childbirth have also been identified with feminist concerns regarding childbearing women although, as I shall show, academic feminism has been more critical of this than those writing within the field of childbirth education that align themselves with feminism. This section of the chapter will consider the nature of these two alternative models. The debate concerning their relationship with the concerns of feminism will be reviewed. My central concern is the extent to which these alternatives can offer women whose pregnancies become seriously complicated a supportive and empowering care context. I argue that these models, like the feminist theorising previously considered, are also constructed through a marginalisation of such women.

Natural childbirth represents an attempt to promote what its advocates refer to as the psychological experience of women, not simply throughout the processes of pregnancy and birth, but also as a determining factor of those processes. Not only should pregnancy and birth be recognised as subjective experiences for women, (rather than purely biological

events), but women should be encouraged to realize and utilise their 'innate' potential to control the nature and outcome of these events. Arney describes concern to privilege the significance of the subjective aspects of childbirth as the insistence that women have 'a face', compared to the assumptions of obstetrics which renders women 'faceless' (1982; p.210). Whilst professional obstetrics had always recognised the subjective dimension of women, its *relevance* to the obstetric event was considered minimal.

The term natural childbirth describes not a unified system of some kind but is an 'umbrella' concept for a variety of techniques (Moscucci, 2003). The techniques had their early expression in the work of Dick-Read (1953) and Lamaze (1958). During the 1960s several approaches to natural childbirth emerged. Their concerns derived from essentially two schools of thought. The first, associated with Dick-Read, emphasised the experience of pain as the product of a process of learning. Through education, pain during childbirth could be reduced. Educating women on the physiological happenings within their own bodies and what they might expect during pregnancy and birth and teaching them relaxation techniques would enable women to take control of the birth process and hence render it a more enjoyable experience. The second school of thought also privileges the psychological dimensions of childbearing women. The psycho-prophylactic school of childbirth education is premised upon the idea that, with certain techniques, women can learn to inhibit the experience of pain, through breathing exercises to aid relaxation and exercises which control specific muscle groups. Both schools and the subsequent approaches which they have influenced represent attempts to 'equip' women for childbirth separate from the constraints of unnecessary obstetric intervention.

Natural childbirth has its contemporary expression amongst childbirth educators who align themselves with feminism: Kitzinger (1984) and Balaskas (1992) in Britain and Arms (1994) in the USA. Kitzinger has described herself as having her feet in 'both camps',

that of feminism and of the natural childbirth movement (Arms, 1994, p.243). Drawing primarily upon the work of Dick Read, she has dedicated herself to formulating techniques and sharing forms of knowledge which effectively prepare women for childbirth of 'joy', an approach which she describes as psychosexual. This compares with childbirth involving intensive use of technology which she likens to rape and describes as '...another form of institutionalised violence against women' (1972, p.78). Emotional aspects of women's birthing experiences are just as significant, if not more so, than the physiological aspects and natural childbirth for Kitzinger is about preparing emotionally for birth so that one can be fully conscious and experience its joy. She therefore prefers to use the concept of 'education for childbirth'. The fifth edition of *The Experience of Childbirth*, within which she propounds this education, considers the experience of caesarean birth in an appendix only. She gives advice on ways in which, during caesareans, mothers and fathers can be involved in the decision making processes and how even this is '...not just an operation. It is a birth experience, if one of a different kind from that for which you hoped. You can make it the best possible given the reality which you face' (1984, p.284). The location of this advice, relegated to the appendices, however, gives testimony to her marginalisation of such experiences.

Arms (1994) describes pregnancy and birth as a natural part of 'female sexuality and creativity' (p.23). She claims that medicalisation of childbirth has produced fear in women and a resultant lack of trust in their ability to give birth successfully and on their own terms. Hospitalisation means that women cannot retain control over their own bodies. Arms argues that women should be informed not through their intellect via medical books but through their 'hearts' (p.142). One way to achieve this is by showing women images of women giving birth naturally, to inspire them and create a sense of confidence in their own ability to give birth likewise. Among 222 pages of commentary on birth, only 8.5 are dedicated to problems in birth. In these pages Arms portrays these problems as manageable

with 'minimal assistance' or disappearing 'spontaneously' (p.134). With a heading entitled "Normalising 'At Risk' Birth", Arms describes a woman's choice of a holistic approach to handling pre-eclampsia, with the woman and her baby going home the day after birth. Risk is not only marginalised, but when considered, the notions of self control that she propounds throughout are equally applied. In some situations this is simply not applicable. For women experiencing serious pre-eclampsia where control of the condition is dependent upon medical intervention, notions of *self* control may not be viable. I shall however show in Chapter Seven how some women during pregnancies subsequent to suffering pre-eclampsia, do indeed try to exert such control.

Natural childbirth in summary is presented as an opportunity for women to express their 'natural' female instincts, with which they can have full confidence. The pregnancy and birth experience consequently becomes fulfilling and empowering. There is an explicit challenge to medicalised birth that suggests an easy alliance with the feminist critique. However, there has been a cautious appraisal of it, although none which directly engages with the issue of pregnancy complications. I now briefly turn to these critical commentaries and suggest that the issue of serious childbirth complications adds further weight to such cautious appraisal.

The first fundamental problem with the natural childbirth model is the universalism inherent within it. Natural childbirth draws upon an 'essentialist discourse of female embodiment' (Brooks and Lomax, 1999). This essentialism, whereby the understanding of women's experiences of pregnancy and childbirth can be discovered in the 'essential' and 'innate' character of 'femaleness', can be criticised because it leads to a universal conception of women's experiences (Annandale and Clarke, 1996) and a failure to reflect women's actual and varied 'embodied experiences' (Brooks and Lomax, 1999). Research has shown how women's experiences and conceptualisation of childbirth are varied

(Nelson, 1983; Zadoroznyj, 1999). I suggest that this is also illustrated with respect to complicated pregnancies and births. The natural childbirth model is by definition founded upon a marginalisation of pregnancies and birth that are not easily encompassed within its definition of 'normal birth'. The work of Arms and Kitzinger illustrate this as suggested previously but so too do organisations dedicated to the promotion of natural childbirth. Lamaze International, a natural childbirth educational organisation established to 'celebrate birth' includes, as its 'philosophy of birth' an association between childbirth and health and the safety of birth outside the hospital context. Normal birth is simply 'nature's' plan for birth, free from medical intervention. The promotion of the normal involves the marginalisation of that which defies the assumption of normality; there is no mention of problematic pregnancies (Lamaze International, 2006). Insofar as the natural childbirth model marginalises such differences between women, then its assumed affiliation with the general concerns of feminism with improving all women's child birthing experiences must be questioned (Annandale and Clarke, 1996, 1997).

The second issue which suggests an uneasy alliance between feminist concerns with reproduction and natural childbirth is the way in which the model actually encourages a furtherance of control over women's lives and bodies. It has been suggested that obstetrics only ever controlled a small part of women's bodies during childbirth. The emergence of natural childbirth has enabled it to control, not simply childbirth, but the woman herself (Arney, 1982). Rather than the nature of contemporary care being understood as representing obstetrics conceding some of its power to women, (for example, as we shall see later, through the apparent accommodation of natural childbirth discourse within *Changing Childbirth*, 1993); it can be understood as a system of panoptic social control through which natural childbirth supports the new 'social [my emphasis] technologies of monitoring and surveillance' (Arney, 1982, p.230). The methods and education of natural childbirth exposes women's subjective self; their subjectivity is privileged through the

entire process of childbearing. According to Arney and Neill (1982), it is the increased potential for control, via increased visibility, which explains why obstetrics quickly accepted and accommodated itself to natural childbirth. This accommodation can be seen within the changing nature of antenatal education (Katona, 1982). Subjecting women to a 'panoptic system of control' becomes redefined within natural childbirth discourse, as providing childbearing women with social support. Childbirth, with all of its psychological and social aspects is now something to be 'managed' *per se*. In recognising the way in which natural childbirth has restructured hospitals, in both physical and interactional terms, Arney suggests that natural childbirth has replaced the 'brutality' of obstetrics. However, he suggests that it has been replaced with another 'secure set of chains' in that, not only is childbirth now the object of control, but also the woman's mind, experiences and whole subjective self. 'Women have participated in obstetrics act of replacing one system of control over childbirth with another more totalising system' (1982; p.236).

Rothman (1982) provides a further example of the link between natural childbirth and the social control of women leading her to challenge the degree to which natural childbirth represents a liberating alternative. She suggests that the goals of natural childbirth have now been replaced with the goals of 'prepared childbirth' insofar as such classes inadvertently prepare women for medical procedures. The coexistence of two, apparently contrasting childbirth discourses, is reflected in the basic contradiction encompassing contemporary maternity care: that whilst there has been a general move away from conceptualising pregnancy as a disease-like state, pregnancy has nevertheless become subjected to increasing forms of technological control (Rothman, 1982).

That the medical establishment co-opted natural childbirth in a manner which *increases* control over women problematised its association with the concerns of feminism. Having already suggested the way in which the recognition of women's experiences places them

within a 'field of visibility' which renders them objects of social control, natural childbirth ideology could be considered as more oppressive than liberating in its implications. Why an ideology, which seems to privilege women's autonomy during the process of childbearing, should be co-opted in a manner which renders it of limited usefulness can be explained by drawing upon the postmodernist arguments of Annandale and Clarke (1996, 1997). They suggest that natural childbirth is a discourse conceived through a *contrast* with the framework offered by the medical model of childbirth. Not only does this mean that the extent of its independence can be questioned, but, perhaps more significantly, they suggest that such an oppositional construct will necessarily attribute power to that which it is opposed: childbirth premised upon a medical model. This theoretical consideration may explain why, in both policy initiatives and actual care practice, natural childbirth remains as 'other' to the medical model of obstetrics. Cosslett (1991) also attempts to explain the limited challenge offered by natural childbirth in terms of its male authorship (e.g. Dick-Read) and the limited degree to which writers such as Kitzinger can therefore turn it into something truly woman-centred'. It would seem therefore that the notion of 'natural childbirth' being allied to 'feminism' in its attempts to subvert obstetric domination over childbearing women remains problematic.

So what are the implications of this for women experiencing serious pregnancy complications? Natural childbirth fails to fully embrace women's lived reality and, I would argue, particularly the reality of women experiencing serious pregnancy complications. Its challenge to an obstetric context considered as oppressive is premised on the assumption of fundamental normality. The medical model, as we have seen through the contributions reviewed in this chapter, does not provide childbearing women with truly woman-centred care. Neither model therefore provides a secure place for responding to serious pregnancy complications. Would it make any sense to bring into the necessary obstetrical context associated natural childbirth notions like consciousness and

psychological preparedness and control? Would this not, considering the arguments reviewed above, simply widen the avenues for control over such women? Ultimately, this remains a purely speculative argument unless research is conducted into such women's experiences. What are their conceptions of natural childbirth? Do concepts of control become so embedded that when problems arise that are uncontrollable they are left with a sense of failure? It was with these kinds of questions and speculations in mind concerning this one alternative model of childbirth, that I approached my research. The feminist critique of medicalised childbirth has also promoted the role of a further, seemingly alternative, approach to childbirth. This model is that characterising the assumptions and ideal women-centred practices of midwifery.

The history of obstetrics indicates that its rise to dominance was achieved through the marginalisation of the female midwife, (Arney, 1982; Oakley, 1993c; Campbell and Porter, 1997). Attempts to subvert this dominance have centralised the role of the midwife as the 'guardian' of a process conceived in terms contrasting to that of obstetrics: pregnancy and birth as 'natural' biological phenomena throughout which women must be enabled to assert their control and autonomy. For example, amongst Oakley's (1980) proposals for an alternative agenda in relation to women and reproduction are a return to 'female controlled childbirth'. The basis of the traditional occupation of female midwifery "...has always been a belief in nature...which amounts to a belief in women as their own deliverers" (Oakley, 1980; p.298). The unity between women and midwives stems from the similarity in their understandings of the process of pregnancy and birth, *both* of which *contrast* with that of obstetricians (Oakley and Graham, 1981). It has also been suggested that doctors and midwives engage in different forms of interaction which stem from their differing perceptions of the nature of their participation in the birthing process. Whilst the midwife has traditionally been taught to 'care', the doctor has been taught to view childbirth as a medical problem and is therefore taught the necessary surgical procedures for intervention

(Scully, 1980; Rothman, 1982). The midwives' ability to provide 'love' and 'support' are considered essential for women experiencing a 'natural' birth and crucial for a 'positive' experience (Oakley, 1993c).

Central to the new midwifery is the concept of a community-based midwifery concerned with the total care of women with uncomplicated pregnancies. Promoting women's control and empowering them to make their own decisions regarding the childbearing process are crucial strategies. It is characterised by a non-interventionist approach so that, for example, women are given opportunities for mobility during labour if they wish and the freedom to choose birth position, unrestricted breastfeeding is encouraged and general social and emotional support becomes increasingly significant (Campbell and Porter, 1997). Continuity of midwifery care is a crucial aspect insofar as it is necessitated for the above strategies to prove successful. Sandall (1995) cites three justifications for individual or specific teams of midwives providing individuals with constant care throughout pregnancy and birth: firstly, women are more likely to feel in control if they are able to express their concerns (only likely if they get to know and trust a particular individual or small group of midwives); secondly, it is claimed that midwives are more likely to provide sensitive care, perhaps simply by virtue of their tendency to be females; thirdly, as previously mentioned, research suggests that 'social support' associated with midwifery care proves beneficial (Oakley, 1993c). It is not surprising therefore that many feminist contributors have sought to promote the role of the midwife as part of an attempt to fundamentally improve women's experience of pregnancy and birth.

According to Campbell and Porter, (1997) the strategies associated with the new midwifery can be closely allied to the concerns of feminism; so much so in fact that they write of a 'feminist midwifery'. Likewise, some within the midwifery profession also make similar claims as to the apparently obvious alignment between feminism and

midwifery (Kirkham, 1986). Recent years have seen further literature from within the profession directly associating the two. For example, Stewart's (2004) edited book for midwives focuses on feminist perspectives on maternity care. However, as with the case of the ideology of natural childbirth, whether the new midwifery can in fact form a useful alliance with feminism is subject to debate and it is in considering these arguments that the significance of exploring the experiences of women with serious complications becomes evident.

The notion of a 'feminist midwifery' is heavily criticised by Annandale and Clarke (1996, 1997), who suggest a number of reasons why the concept should be problematised, along with any presumption of a close relationship between 'feminism' and 'new midwifery'. Firstly, they criticise the assumption of a unified feminism which is implicit in arguments concerning feminism's association with midwifery. It is argued that new midwifery (along with natural childbirth) shares an ideological basis with *radical* feminism. Their account of gender and reproduction, influenced by postmodernism, undermines the essentialism inherent within radical feminism by promoting the deconstruction of gender dualities. They therefore undermine the ideological basis for the *assumption* of a unity between 'feminism' *per se* and midwifery. A second point made by Annandale and Clarke concerns the way in which the new midwifery has been construed through a *contrast* with obstetrics. Obstetrics and midwifery have been theorised as internally coherent and distinctive models of childbirth practice, (Graham and Oakley, 1981; Rothman, 1982). However, Annandale and Clarke suggest, because the latter has been constructed in contrast to the former, the new midwifery is simply an antithesis which confirms the dominance of obstetrics. This dominance is evident in the way in which the concerns of new midwifery are given consideration *only* against a background of obstetric considerations and this becomes visible in relation to the perspective taken towards problematic pregnancies. I suggest that this can be identified in the perspective taken by

the profession generally. In 2005 the Royal College of Midwives began a campaign to promote in their working practices 'normal birth'. The definition of normal birth includes that of being low risk at the start and remaining so throughout pregnancy and birth.

'The RCM recommends that midwives value, support, and develop their own skills and knowledge, and those of their colleagues, in the area of normal childbirth.' (Royal College of Midwives, 2005)

The focus is therefore on the normal. Problematic pregnancies become considered as legitimately belonging to the realm of obstetrics. I suggest therefore that, just as problematic pregnancies illustrated the 'otherness' of the natural childbirth model, thereby questioning its truly alternative nature, so too do they in relation to new midwifery.

Not all feminists readily accept therefore the notion of new midwifery as necessarily promoting the interests of women. Whilst some analyses of midwifery literature suggest an unproblematic relationship between the new midwifery and feminism (Campbell and Porter, 1997), others reveal that midwives are a '...varied group who embrace a range of ideologies of childbirth which are not necessarily feminist....' (Annandale and Clarke, 1997, p.522). Conflicts between women and midwives also suggest a need to problematise the notion that midwifery necessarily promotes the control and autonomy of women. Annandale's (1987) study of patient control in a midwife-run birth centre showed how the behaviour of midwives sometimes prevented women from raising concerns about complications. This was explained in terms of the midwives' concern to emphasise 'normality'. The result, however, is a failure to consult women about decisions during labour (Sandall, 1995). Whilst Brooks' (1990), exploration of attempts to provide user centred care found a model of health care provision amongst midwives which was distinct from the medical model, midwives were found to be constrained in practice and socialised into a more medical form of care provision. Similarly, research by Weitz and Sullivan

(1985) revealed the increasing pressure upon lay midwives in Arizona to adopt a more medical model of childbirth. Such research suggests that there may be a difference between theory and practice in the extent to which a new midwifery is able to promote a more liberating birth context. The postmodernist notion of midwifery being defined only in contrast to obstetrics may provide some explanation as to why the ideals of new midwifery may continue to be thwarted (Annandale and Clarke, 1996, 1997).

Given the critical arguments above, the assumption of new midwifery and natural childbirth equalling an automatic prioritisation of women's needs and a challenge to obstetrics must be problematised. Some literature has suggested that both the natural childbirth model and the concept of new midwifery may in fact prove as oppressive as they are potentially liberating. As Arney states, alternatives to obstetrics have arisen within the rule that birth should occur within a flexible system which recognises the centrality of women's subjectivity and within which the midwife is promoted as the primary supporter but against a backdrop of obstetrical expertise. This rule '...comes to resemble a liberating rather than constraining force (Arney, 1982; p.240). 'Alternatives' which are gauged in terms of the new midwifery and natural childbirth are conceived as oppositions to the medical model and therefore remain limited in their liberating potential (Annandale and Clarke, 1996, 1997). The oppositional nature of these alternative models is particularly pertinent with respect to serious pregnancy complications, for it is here, I suggest, that there is an inherent deference to the skills and knowledge associated with obstetrics. It is here that women with complications become marginalised by both natural childbirth and new midwifery models of care and situated firmly within the ideology and associated practices of the medical model. I suggest that it is here that any assumed alliance between alternative childbirth models and feminism become challenged insofar as feminism professes a concern with improving the health care experiences of all women. To discover the extent to which these suggestions have any credence at the level of the lived reality of

women with serious pregnancy complications demands an exploration of their experiences.

The Sociology of Risk

The introduction to this chapter argued that there was a need to situate the concept of 'risk' as a basis for understanding women's experiences of pregnancy complications. The work of Corbin (1987), reviewed earlier in this chapter, began to reveal the importance of pregnant women's understanding and response to risk. The argument, however, that risk needs to be considered further primarily developed through a consideration of the data which emerged from my research. The sociology of risk was not considered as significant to my concerns when the research began. Given the emergence of risk as a theme, I found it necessary retrospectively to review some of the key concerns of this specialism within sociology and to consider what it might offer in terms of developing a critical framework which could encompass complicated pregnancies. In Chapter Eight I consider the relevance of this literature to my specific findings. The purpose of this final section of Chapter Two is to briefly review some key contributions.

Academic considerations of risk have been largely dominated by the disciplines of risk assessment and risk analysis, themselves dominated by the subjects of economics, statistics and business management. That sociology should specifically be involved in the 'social transformation' of risk analysis, that is, that sociologists should develop a more sociological approach to it, was something promoted by Short (1984, p. 711). Sociological input could, he suggested, focus upon the social context to risk; perceptions of risk (hitherto dominated by psychology) and the influence of the media in constructing understandings of risk. In 1999, Tierney published her article '*Towards a Critical Sociology of Risk*', arguing that since Short's promotion of a sociology of risk there had

been a growing number of studies, but still little in the way of cohesive theoretical perspectives on risk within the discipline. The only two examples excluded from this conclusion were the sociological works of Beck (1992) and Luckmann (1993), though both of these focused upon the risks linked with technology in modern societies as compared with some of the areas Short had isolated as worthy of consideration. As well as similar areas to those promoted by Short, Tiery was keen to identify the relationship between power and risk as an area for investigation. By 2004, Zinn was able to publish a literature review on the sociology of risk citing over one hundred references since 1995. Three main perspectives had developed.

The first main perspective is an approach referred to as 'risk society' which understands society in terms of 'uncertainties', the focus being on the ways in which society then develops strategies to promote a sense of certainty. The second approach is the socio-cultural one which analyses the ways in which risk is culturally and, through personal experience, constructed. Thirdly, Zinn identifies the governmentality approach. This has various concerns, the shared focus being, however, on the ways in which institutional discourses and procedures construct risk.

Zinn's review included only six contributions that were directly related to the field of health and illness (Maticka-Tyndale, 1992; Bloor, 1995; Nettleton, 1997; Denscombe, 2001; Duff, 2003 and Hobson-West, 2003). Similarly, Blaxter's (1999) review of the twenty four project proposals accepted by the British Economic and Social Research Council as part of their project Risk and Human Behaviour, showed that only five were concerned with the constructed nature of risk in relation to health and none of these were concerned with pregnancy. Given that the very concept of risk has developed as a central tenet upon which obstetrics gains its legitimacy and given the attempt to challenge that dominance by contesting the primacy of risk in the majority of women's pregnancies, I

found it remarkable that pregnancy had not been more directly considered in relation to the developing field of the sociology of risk. In principle, for example, the medical discourse of obstetrics and the feminist critique could be analysed within the governmentality approach identified by Zinn and women's engagement with risk within the socio-cultural approach. In Chapter Eight I suggest ways in which such approaches may be useful in making sense of my own data.

I managed to identify only four contributions on pregnancy which explicitly address the issue of risk, and I briefly relate their key points to show the way in which research on pregnancy and birth can be usefully integrated with the sociology of risk. Firstly, Zadoroznyj's (2001) research in Australia could be said to reflect the socio-cultural approach. She considered how perceptions of risk changed with women's experience of pregnancy. Based upon the birthing stories of fifty women, she found that they became more confident and this impacted on their decisions as consumers of maternity care, with some women in subsequent pregnancies, for example, preferring midwifery-led care. She suggests that this is because the dominance of risk notions is reduced through the confidence of experiencing birth. Zadoroznyj's contribution is important in that it identifies the ways in which women develop their own ideas concerning risk. She considers women's engagement with risk only in relation to the way it influenced their consumer decisions regarding maternity care. However, I will argue later in this thesis that women's engagement with risk has a broader significance: it indicates a challenge to the existing literature concerning medicalised childbirth.

A further contribution is that by Lankshear *et al* (2005) who explored the impact of the concept of 'risk society' in relation to maternity care. Whilst morbidity has been reduced, the expectation of childbirth as being risk free has increased and staff face the pressure of conforming to such an ideal. Their research was conducted in three maternity hospitals

where, in an increasing attempt to diminish mistakes, a computerised decision support system is to be implemented. Their results showed the complexity of decision making and the difficulty in trying to bring such a system into a medical practice context. This research usefully illustrates the linkage between research around childbirth, in relation to the health professionals involved and themes emerging from the sociology of risk.

Thirdly, Kirsi (2000) researched Finnish parents who were advocates of home birth and the way in which, rather than marginalising risks, they considered risk in different sorts of ways. These parents' decision-making was the product of engaging directly with knowledge of medical risks, weighed up against the potential iatrogenic impact of medical intervention and the moral risks of deviating from the hospitalised ideal. This type of research illustrates the way in which risk is complexly constructed.

Lane (1995) argues that the issue is not whether there are risks in childbirth but rather the way in which the notion of potential risk is used in a way that leads to the social control of women. The dominance of the medical model leads women to consider risk in terms of their lifestyle or biomedical concerns rather than perceiving their levels of risk as being linked to their social structural position. Furthermore, the risk of iatrogenic effects of intervention is downplayed. Lane largely supports existing critiques of medicalised childbirth through a focus on the way such medicalisation is justified through the concept of risk. Lane is concerned, therefore, not with considering the risks of childbirth and how they may be experienced by women, but rather with the way the concept of risk has been used by doctors. I believe that analysis should focus on the latter but not to the detriment of the former. The existence of risks in pregnancy and birth raises some challenges to feminist critiques which are only sustained through a marginalisation of the experience of women for whom such risks become realities.

In terms of quantity of research, contributions within the sociology of risk focused upon pregnancy are sparse. If it is the case that risk is central to women's constructions of childbirth expectations and experiences, then it is essential that an analysis of risk be incorporated into the feminist challenge to medicalised childbirth. Whilst Corbin's (1987) research had identified the importance of risk in some women's experiences of pregnancy, she did not draw upon insights from the sociology of risk; this is understandable given that the sociological consideration of risk had only begun to develop three years previous to her research. The work reviewed above provides some interesting ideas which might be useful in expanding the existing feminist critique in a manner which integrates the reality of risk in women's pregnancy experiences. Chapter Eight gives further consideration to this in the light of this study's findings.

Summary

In this chapter I have suggested there are essentially four themes that characterise critical feminist inspired literature on medicalised childbirth. Firstly, there are the arguments suggesting the inability of maternity care dominated by the medical model to meet the needs of women insofar as it conceptualises them and their needs in a narrow way. The supervision and intervention that often characterises the latter are considered as producing iatrogenic consequences for women, physically, emotionally and socially. This constitutes the second theme evident in the literature. Thirdly, the literature reveals a theme relating to the wider social political context whereby the very assumptions and practice of the medical model regarding childbearing serves to reflect and thereby reproduce women's subordinate position. Fourthly, the literature explicitly and sometimes implicitly suggests that medicalised childbirth can be successfully challenged through promoting alternative models of childbirth. Natural childbirth and the role of midwives as expressing an

alternative childbirth framework have been promoted.

The argument of this chapter highlights two features of particular importance for what follows. Firstly, I have suggested that there exists a fundamental limitation in most existing contributions to the feminist literature on medicalised childbirth. This limitation is the failure to directly integrate a consideration of problematic pregnancies into an analysis and challenge to the medical model. There is some empirical work on problematic pregnancies which has contributed to an understanding of the experiences of women suffering serious pregnancy difficulties. Such work provides a basis from which to ask fundamental questions regarding the sufficiency of the feminist critique in providing a framework which incorporates such women. The contributions reviewed in this chapter, however, have not explicitly asked those questions. Primarily such work was not concerned with the way problematic pregnancy experiences have theoretical application regarding the feminist critique. The possible answers have yet, therefore, to be suggested. Secondly, I have agreed with those who have problematised any simple association between the alternatives promoted and the needs of women and have suggested that the issue of pregnancies with serious complications further demonstrates some of the arguments forwarded. Thus, with regard to the issue of problematic pregnancies, the existing literature is itself problematic. I have argued that there is a need to engage and research directly the phenomena of such pregnancies so that the existing feminist critique may be developed. This might be partly aided through a consideration of the concept of risk and thus the latter part of this chapter briefly considered some main features of the sociology of risk and its limited consideration of issues relating to pregnancy and childbirth. In order to rectify both the marginalisation of serious pregnancy complications within the existing theoretical feminist challenge and the failure to integrate existing empirical work on complications within that challenge, I decided to research women's experiences of pre-eclampsia. In the following chapter I present the methodological considerations as they relate to this research.

Chapter Three

Methodological Considerations

The concern of this chapter is to reveal the assumptions and procedures that defined this research and to describe and give a preliminary evaluation of the research design. It begins with identifying the way in which I entered the research, privileging qualitative forms of enquiry and feminist critiques of mainstream research. Influenced in part by feminist standpoint epistemology which highlights the importance of researchers revealing the way in which they are implicated in the entire research process, Chapter One presented my own account of suffering from pre-eclampsia. In this chapter, I consider the impact of this experience upon the research. The sample is then considered in terms of recruitment and characteristics and I present a justification for this and also for the inclusion of the husbands, partners or mothers of the women who experienced pre-eclampsia. Next, the chapter critically discusses the methods used in the research. These were semi-structured interviews, solicited and unsolicited written accounts and a questionnaire to establish demographic profiles. The ethical dimensions of my research are then discussed. I was influenced, not only by formal professional bodies like the British Sociological Association, but also by wider feminist conceptions of ethical procedures in social research. A critical consideration of procedures for making sense of the data is lastly presented. I have come to characterise my analysis procedures as heavily influenced by, but in no way a straightforward example of, grounded theory. Though I present these various methodological considerations in the context of intellectual and personal persuasions concerning the research process, ultimately this process was always constrained by the fact that it was self funded and carried out by a part-time student. I had

to make certain decisions influenced by associated practicalities and, where these are of significance, I consider them in this chapter.

Guiding Assumptions

The notion that value freedom is both necessary and desirable to the sociological research process continues to be debated. Weber (1949) argued that complete value freedom was impossible. The very decision to investigate particular phenomena involves a judgement about the importance of those phenomena. Becker (1967) promoted a 'sociology of the underdog', arguing that research should focus upon giving the powerless a voice. Feminists, as this chapter will show, have also challenged the concept of value freedom, espousing instead research which is motivated by the need to identify and challenge women's oppressive social conditions. Revealing one's assumptions places a demand upon researchers to critically evaluate work in light of their assumptions and, secondly, empowers the reader to consider the validity of the research in the context of these revealed assumptions. I approached this research with a preference for qualitative forms of research, stemming from a conviction that the social world is premised upon subjectivity. Secondly, I am convinced of the legitimacy of feminist critiques of mainstream social enquiry and, therefore, I tried to conduct the research in the manner proposed by those promoting feminist procedures for social research.

As an approach to conducting social research, positivism has come under attack. The guiding assumptions of this approach, that people are products of the social environment, making predictions about their behaviour possible, and that social science should strive to mimic the methodological strategies and considerations of the natural sciences, have been challenged. Positivism privileges those methods which marginalise the subjective

understandings of social actors and is therefore characterised by a preference for quantitative methods of enquiry. The inappropriateness of such methods for investigating the 'inter-subjective world' (Silverman, 1985), and the 'manifest content' (Hammersley, 1993) which such procedures produce, has led to the continual development of forms of social enquiry which privilege the subjective world of the research participant. Qualitative enquiry is not subject specific, method specific, nor theory specific (Denzin and Lincoln, 1998a). Rather it is a diverse enterprise. The characteristics of qualitative research have been isolated by many authors (Taylor and Bogdan, 1984; Silverman, 1985; Denzin and Lincoln, 1998b). From these contributions I suggest it is possible to isolate three major characteristics of qualitative research which have also come to define my own research.

Firstly, it is an attempt to explore and gain a greater understanding of the experiences of the social actors. An attempt is made to empathise with people in order to understand them more. The intention of my research was to explore with women their experiences of pre-eclampsia. As an under-explored phenomenon I chose to privilege the subjectivity of the women themselves in an attempt to make visible this experience. There is a humanistic angle to qualitative enquiry in that, rather than attempt to detach oneself from the research participants in order to claim objectivity; the aim is to identify with them in order to produce valid accounts and descriptions of their social reality. I approached my research with the assumption that I would identify with the women due to my own experience of pre-eclampsia. The reality of this identification, however, is critically reviewed later in this chapter.

Secondly, qualitative research allows the researcher to be flexible in her consideration of what are the important questions and the relevant natural setting to observe and the people to be sampled. Qualitative research is frequently characterised by an emergent design, which is one that evolves over time (Maykut and Morehouse, 1994). My research

was characterised by this. As an exploratory piece of research, I knew that this study needed to be open to what emerged from the early accounts of women. The most significant emergent issue in terms of study design was the need to explore the experience of those closest to the women at the time of their illness. This is considered in more detail later in this chapter.

Thirdly, and given the above, qualitative research requires ongoing data analysis as opposed to analysis being defined as a distinctive and separate phase of the research process. Such ongoing analysis yields new insights which can then be explored. It also allows the researcher to narrow the focus of the enquiry. This suggests, therefore, that rather than the researcher pre-determining what is of significance, the data will be studied for what they reveal as of significance to respondents and will therefore direct the nature of further investigation. Categories of meaning, upon which theoretical conceptualisation can be built, are inductively derived from the data (Silverman, 1985 and Denzin and Lincoln 1998a). This approach to making sense of the data is one influenced upon the strategies of grounded theory (Tesch, 1990, Corbin and Strauss, 1998), an analytical approach defined by the characteristics just described and considered in detail further in this chapter.

As well as privileging qualitative strategies of enquiry, I also began this research influenced by feminist approaches to conducting social research (Stanley and Wise, 1983). Some feminists have noted compatibility between qualitative methods and feminist research. Both, for example, share a focus with exploring subjectivity, including that of the researchers, and therefore stress the importance of reflexivity (Mies, 1993). However, feminist and qualitative research do have points of contrast and it is these which problematise any assumed relationship between them. Thompson (1992) expresses the point of contrast at the level of 'agenda'. That is, whereas qualitative research is not theory-specific, feminist research has a theoretical and political agenda, that of revealing

and contesting the oppression of women. It is possible to integrate feminist concerns into any technique of research (Risman, 1993). This can be achieved through quantitative research practices. Jayarante (1993), for example, suggests that quantitative methods are not inherently oppositional to feminist research aims and that what is required is change in the traditional research processes within which they are used. I did not engage in quantitative techniques. This was not because of any assumed disjuncture they might have with feminist inspired research. Rather my qualitative approach was inspired simply by the focus of my research. Exploring women's experiences of a pregnancy disorder is best achieved through qualitative interviewing. I was not interested in, for example, the statistical comparison between the experience of this disorder and socio-economic variables. Whilst this would possibly be an interesting consideration, I wanted to understand the subjective experience of the condition. However, it is not the qualitative nature of my research that renders it feminist. According to Harding (1987) it is primarily the epistemological assumptions which characterise a piece of research as feminist, that is, the researcher's assumptions regarding what is valid knowledge, how it can be made known and the nature of the relationship between the researcher and those she or he researches. Many have isolated the concerns of research that characterise it as feminist (for example, Mies, 1993; Harding, 1987; Westkott, 1990; Stanley and Wise, 1990 and Campbell and Wasco, 2000). From reading these contributions, I suggest that it has four essential characteristics and now isolate the way in which these four also define my own research, making it therefore explicitly feminist in orientation.

As mentioned before feminist research has a political agenda. It is research not just about women but for them. Research which is concerned with women's experiences and that investigates such with the intention of improving their conditions of existence is feminist inspired. I approached my research not with the aim of simply describing their experience but with the hope of instigating further discussion and research into ways to

improve the physical and subjective experiences of women suffering from problematic pregnancies. I assume the position of Westkott (1990) when she argues that:

‘Women’s devaluation and the consequences of their devaluation are reinforced by a social science which regards the conditions while systematically ignoring alternative possibilities.’ (p.63)

Therefore, in Chapter Nine I discuss maternity policy and make suggestions regarding improvements to the care received by women with serious pregnancy complications.

Conceptualising women’s experiences as a valid source of knowledge is another characteristic of feminist research. As shown in Chapter Two, feminists have attempted to challenge male-dominated ideas of the process of pregnancy and birth, through contesting the language used to describe it and the procedures legitimating control over it. However, with little research on women who suffer serious complications of pregnancy, knowledge of pre-eclampsia for example, is primarily described through obstetrical language and forms of knowledge. I wanted to not only show how women’s knowledge of it manifested in their personal accounts of suffering, but to also use this as a basis upon which to construct a challenge to existing regimes of care.

Feminist research extends ethical concerns into the very nature of the relationship between researcher and respondent, suggesting that hierarchical and exploitative relationships be replaced with more equal and beneficial ones. Influenced by the work of Oakley (1981), I attempted to conduct my research in a manner consistent with such principles. This involved, for example, truthfully responding when women asked me whether I had suffered from pre-eclampsia and sharing, when requested, my own experience. I found this profitable in that subsequent to this sharing women often opened

up much more. However, whilst I had thought through and tried practically to embrace the principle of rejecting the hierarchical nature of the relations often characterising research relationships, what I was unprepared for was my sense of inferiority in relation to some of my respondents which derived from socio-economic differences. Put simply, as somebody originally from a lower- working class background, I experienced some of the women as powerful. The commonality of our experience of pre-eclampsia did not totally eradicate this sense. Nevertheless, in terms of the actual interviews, whilst feeling often socially and culturally inferior, I also have to agree with Wong (1998) who described how, despite embracing feminist principles, the reality of her interviews demonstrated her own power in that specific context. She describes how she found herself:

‘...speeding up the direction by occasionally repeating back to the respondent her thoughts...and speculating aloud what I thought the respondent was trying to articulate but was unable or reluctant...’ (p.12)

On reflection, I would have to admit to sometimes engaging in such actions primarily as an attempt to claim power and status in a context where I felt otherwise powerless.

Fourthly, feminist research is premised on a critique that objectivity can equate only to a lack of researcher involvement. Wilkins (1993), however, wrote about the significance of our emotions in the research process. Her description of her own experience of interviewing and the impact of her own emotions upon it describes my own experience.

‘...I conducted interviews in both secure and insecure moods...When I felt secure I felt nourished and did not feel personally threatened...Rather than manipulating, manoeuvring or extracting data and then withdrawing, I felt the wish to reach out and know people in their particularity...I was flexible, calm and open. I accepted more and sought to control less.’ (p.96)

It can be argued that what counts for objectivity in mainstream research, like a removal of the researcher's own autobiography from the process of research, is far from objective in that it conceals the evidence of the researcher's inevitable implication in the research process (Stanley, 1990). Harding (1987) argues that in fact the researcher's beliefs and experiences that direct the research are '...part of the empirical evidence for (or against) the claims advanced in the results of research' (p9), and must be revealed in order to make their impact upon the research open to critical consideration. By virtue of my own previous experience of pre-eclampsia, I was emotionally as well as intellectually influenced and interested. It is for this reason that I have chosen to include, in Chapter One, my own account of pre-eclampsia. I now consider its possible implications for the research process.

What are the implications of this history for the conduct of research on the subject area with which it deals? Whilst such an experience undoubtedly raises issues with respect to the effective pursuit of the research, I believe it also has intrinsic advantages. Such a personal relationship with pre-eclampsia potentially produces two major problems. The first relates to the impact upon the processes of data collection and analysis, the second, to my own emotional well being.

The nature of qualitative enquiry privileges the subjective world of both researcher and those whom she researches. To comprehend the subjective experiences of those in whom we are interested demands an ability and willingness to identify and empathise with their experiences. Furthermore, the researcher must to some extent allow the 'data to speak for themselves' by not imposing a pre-determined structure of 'what is relevant' upon the data analysis process. These two aspects of the process of conducting qualitative research enable the researcher to produce more valid accounts of social reality. Here lay both the potential dangers and advantages of such an approach. Here too, I will suggest later, lay the problems and positive aspects of having such a close relationship with the subject matter of

the research. Whilst it is not possible to be a detached objective observer of social reality, if one is to understand that reality as a researcher, there is ultimately a need to create a degree of 'autonomy' or 'space' within which to describe from the vantage point of those in whom one is interested. My own experience of pre-eclampsia potentially problematises my ability to create that 'space'. For example, to what extent might my experience have influenced the direction of interviews? To what extent did I impose a predetermined structure, defined by aspects of my own experience, onto the data? My response to such questions is not to deny the potential of these two problems. I argue instead that my own appreciation of such issues provides for a critical reflexive attitude towards the research process. I have had to, and will continue to, confront accounts which in many ways contradict my own experience and my own expectations of others' experience. For example, I began the research with the intention of exploring only the accounts of the women themselves. Furthermore, I assumed that many would share in my very negative perspective on care received. The reality for the women in my sample confronted me with the need to consider the experiences of significant others as well as give voice to the fact that many women isolated positive aspects of their care. By revealing my personal relationship with pre-eclampsia I am seeking to empower readers to look more critically at my research in the light of such an experience. I also create, for myself, the necessity of constantly being 'on guard' and 'keeping in check' the impact of my own experience upon the research process.

The second major problem relates to the emotional impact of undertaking research on an issue with which I am historically and contemporarily personally bound. Reinharz and Davidman (1992), in their discussion of feminist interview research, consider the specific issue of stress which feminist researchers may encounter during research. Engaging in issues which traumatise women is in itself a difficult task. My engagement with women who often expressed the trauma that pre-eclampsia produced for them, engendered various

personal emotional responses - from sadness through to anger. I have sometimes been left feeling depressed, tired or even apathetic. Occasionally, I have found it difficult to distance myself from accounts which bore some similarities with my own. Ultimately, one finds strategies to deal with the emotional impact of this and it has to be seen, as Reinharz and Davidson (1992) suggest, as another one of the academic and personal challenges of feminist social research. The danger, I feel, is not feeling the emotions *per se*, but rather in allowing them to disempower me in my ability to conduct the research. I feel that my experience and the emotions it produces can and does empower me. I believe it provided, in the main, for a more authentic empathy and understanding of my respondents' experiences.

Secondly, it provides me with another element of motivation for pursuing the research. Feminists criticise both the possibility and desirability of adopting a so-called value free approach to research, which in practice necessitates an indifference to those in whose experiences we are interested. Instead a 'conscious partiality' has been promoted (Mies, 1993). The researcher is aware of her 'double consciousnesses' as both an academic researcher and a woman researching other women with whom she may share life experiences. Being conscious of the consequential partiality allows for a self reflective stance which can provide a check against the potential 'distortions' that the limited perspective of either an academic or woman can provide. Rather than a shared experience providing a basis for 'bias', it can provide for greater, critically reflective empathy, conducive to higher validity in women's accounts. Such personal engagement has been promoted by feminists (Oakley, 1981; Mies, 1993; Westkott, 1990) and need not be antithetical to good research practice. A shared personal experience can empower the researcher to engage in the project with more motivation, commitment, authenticity and rapport. My experience of pre-eclampsia presents me continuously with various academic and personal issues throughout the research project. That these issues should be engaged

with I accept; that these issues necessarily problematise the research I dispute since to arrive at such a conclusion is to neglect the very real advantages that also derive from such a shared experience.

Sampling Strategy and Sample Characteristics

In seeking a sample of women for my research, I was presented with various choices. Initially, a choice had to be made about the context from which I wanted to research women. This would determine the sampling strategy. I could seek women who had already experienced pre-eclampsia or I could seek opportunities to undertake observation research in hospital settings where women were admitted and treated for the condition. Of course, both strategies could have been used. I believed the latter to be deeply problematic given the traumatic nature of the illness and my status as a research student. I doubted very much that I would get approval for such research. Furthermore, many women with serious pre-eclampsia may know very little about what is going on around them, problematising issues of informed consent. On a practical level, this research was not funded and needed to be conducted around work and family commitments. Waiting in maternity units or being able to go when a pre-eclamptic woman admitted was simply an option never available to me. Ultimately, I therefore chose to include women who had already suffered from the condition. I could have sought respondents by gaining permission to contact patients who were attending or had attended a particular maternity unit. This would, of course, have involved presenting the justification of the research to a medical research committee and at that time the research ethics committee at Milton Keynes hospital was not approving any qualitative research. Furthermore, I felt the need to approach women from a stance which did not relate me to the medical profession. I had surmised that, if any of the women were going to be critical of the information and care given, then a context within which they did

not in any way relate me to the profession, would provide the necessary space for them to express such concerns. (This assumption is reviewed in Chapter Nine). An alternative to these various sampling strategies was to use a self-selecting method whereby I would advertise the research in specific forms of literature and wait for the women to contact me. This is what I decided to do.

The research was advertised in a national pregnancy magazine (Babycare and Pregnancy) and the newsletters of two interested charities: BLISS (Baby Life Support Systems) and APEC (Action on Pre-eclampsia). Due to financial and travelling constraints, I requested that only women who lived in the Hertfordshire or North London area make contact (Appendix 14). The pregnancy magazine produced few responses (four in total). The Action on Pre-eclampsia newsletter was therefore chosen because I assumed it would have a readership of women who had indeed suffered from the condition and who might, because of their assumed concern to support APEC and in turn be supported through its various support facilities, be more willing to participate. Twenty women contacted me through the advert in APEC's newsletter. Pre-eclampsia is a major cause of prematurity and BLISS is a charity involved in supporting neonatal units and parents of babies who have to spend time in them. Again, I surmised that such a publication would possibly have readers who had experienced pre-eclampsia and who would be willing to take part. Eleven women contacted me via the BLISS newsletter. Women who were interested were asked to write or telephone me directly although those potentially recruited through the pregnancy magazine sent their letters directly to the Editor who then forwarded them unopened. From the thirty-five women who initially made contact, thirty went on to participate in the research. The accounts of six significant others were collected: three husbands and three mothers of the women in the original sample. The decision to incorporate these emerged from the concerns of the original data set. Thus, a random sample of ten significant others who the original women participants had given permission

for me to contact were asked whether they would also take part in the research.

The sample was therefore self-selecting. This obviously raises some challenges to the representative nature of the sample of women involved in the research. This method of recruitment and, in particular, the newsletters used to advertise the research, suggests that the women who decided to participate may not reflect the wider population of women who have experienced pre-eclampsia. The research sample possibly consists therefore of a particular type of pre-eclampsia sufferer. I had been concerned, for example, that perhaps I had only captured the experiences of those who might be more critical than other women who had suffered from the disease but who were not inclined to relate to the various charities. However, the data revealed that many women in the sample were very positive about aspects of the care received. This is revealed particularly in Chapters Five and Seven.

The resulting sample consisted of thirty women living mainly in the Hertfordshire and North London area. Twenty-four had suffered pre-eclampsia within the previous two years prior to the commencement of the research, six within five years. The accounts were of course all reflections upon pre-eclampsia. The possible challenge to the usefulness of the research which this produces is considered in Chapter Nine. The sample turned out to be largely white and middle class. Only one of the women was Black Caribbean and two described themselves as 'White Other', other than White European that is. All of the women were over twenty-five at the time of the research, with eleven being over thirty-five. Any conclusions reached are obviously circumscribed by these facts, and no claim can be made that the results are necessarily generalisable for all women who have experienced pre-eclampsia. Nevertheless the accounts are interesting and whilst limited in their generalisation, they do, as will be argued, allow an important challenge to be made regarding existing feminist theorisations of pregnancy and childbirth.

The table overleaf identifies some socio-economic characteristics of the sample of women. Their social class position was categorised according to the National Statistics Socio-economic Classification (NS-SEC), (Office for National Statistics, 2000b) and was derived using the 'simplified method', with their current or previous paid employment being measured using the 2000 Standard Occupational Classification (Office for National Statistics, 2000a). Where information was not made available this is indicated (NA). The table also identifies the method of data collection for all respondents. Interviews conducted face to face and via the telephone are indicated by (F) and (T) respectively. The parity of the women who had experienced pre-eclampsia is also identified.

Social characteristics of the research participants and data collection method

Name	Age from	Ethnicity	NS-SEC	Method of Data collection	Parity	Method of Data Collection (significant other)
Fran	30-34	White European	2	Interview: (F)	1	Written account (Husband John)
Cerri	35+	White European	3	Interview: (T)	2	
Belinda	25-29	White European	3	Interview: (F)	2	Interview: (F) (Husband Steve)
Mags	30-34	White European	2	Interview: (T)	1	
Sharon	25-29	White European	3	Written Account	1	
Nadine	35+	White European	2	Written Account	2	
Sandra	30-34	White European	3	Interview: (F)	4	
Julie	25-29	White European	3	Interview: (T)	1	
Linda	30-34	White European	2	Interview: (F)	2	Interview: (F) (Mother Andrea)
Ellen	25-29	White European	1	Interview: (F)	2	
Carol	N/A	White European	2	Interview: (F)	N/A	
Pauline	35+	White European	3	Interview: (F)	2	
Brenda	30-34	White European	2	Interview: (T)	2	
Irene	35+	Black Caribbean	2	Interview: (F)	1	
Lorraine	30-34	White European	3	Interview: (F)	1	
Kari	35+	White European	2	Written Account	2	
Bella	25-29	White Other	2	Interview: (F)	1	
Mary	35+	White European	7	Written Account	3	Written Account (Mother Rose)
Jane	35+	White European	2	Written Account	1	
Terri	30-34	White European	3	Interview: (F)	1	Interview: (F) (Mother Jane)
Pat	30-34	White European	4	Interview: (F)	4	
Tracey	30-34	White Other	2	Interview: (F)	2	
Amanda	30-34	White European	2	Written Account	2	
Diane	35+	White European	2	Interview: (F)	3	
Suzanne	30-34	White European	3	Interview: (F)	2	
Angela	35+	White European	3	Interview: (F)	3	Diary (Husband Alex)
Joanne	35+	White European	2	Interview: (F)	2	
Anne	30-34	White European	3	Interview: (T)	1	
Emma	35+	White European	6	Written Account	1	
Laura	NA	NA	NA	Interview: (F)	2	

The women who participated had variable experiences of pre-eclampsia in terms of when it had occurred in relation to any other pregnancies and whether they had had multiple experiences of it. It is possible, initially, to identify two groups of women. The first group is those who experienced pre-eclampsia in their first pregnancy. Twenty-seven of the women fell into this group. Secondly, a much smaller group of three women experienced pre-eclampsia in a pregnancy which followed an uncomplicated (by pre-eclampsia) pregnancy: these were Sandra, Pat and Kari.

Post pre-eclampsia, it is possible to divide the women into a further three groups. Firstly, there were those women who had multiple experiences of pre-eclampsia, of which there were eight: Nadine, Linda, Ellen, Pauline, Brenda, Tracey, Suzanne and Diane. The significance of these multiple experiences will initially become apparent later in this chapter but will be given closer consideration in Chapter Seven. Sixteen women form the second group and these were those who, at the time of the fieldwork, had experienced no further pregnancies. The final group comprised six women who experienced a subsequent pregnancy uncomplicated by pre-eclampsia: Amanda, Joanne, Cerri, Mary, Belinda and Laura.

The inclusion of accounts from women's significant others was motivated and justified on three principal grounds. Firstly, interviews with women and written accounts produced by them revealed that their illness was not experienced as a physical and emotional event in isolation from their social and emotional relationships. When women spoke or wrote of their experience of pre-eclampsia, they also spoke or wrote of the role and experience of their husbands, partners, mothers, fathers and friends. These 'significant others' played various roles including that of emotional and practical supporter, advocate, counsellor, and 'witness'. The women themselves often considered the experiences of their 'significant others' as an important element of their own illness experience. So too, therefore, should

the research.

Secondly, women experienced pre-eclampsia within a social context partly defined by their existing relationships. The questionnaire sent to all participants revealed that the overwhelming majority identified at least one significant other as being 'with them the most' during their illness. Along with the motivation described previously, it therefore seemed crucial to recognise and 'give voice' to some of these 'others'. From twenty-nine questionnaires received, twenty-six identified the husband/partner as being 'most with them', either solely or with others. Ten identified their mothers as being 'most with them'; again either solely or with others. From my sample therefore, the two most identified 'significant others' were the husband/partner and mother. For this reason, accounts were sought from a number of these.

Feminists have promoted the need to contextualise women's experiences socially and politically. They have argued that there is a need to treat women as 'whole persons' with many dimensions. In practice, however, they have often paid little attention to relationships with others which may impact upon their experience. It became clear, as the study progressed, that to have attempted to understand women's experiences of pre-eclampsia without accounting for the experiences of those closest and 'near' to them at the time, would have been to have reproduced the very one-dimensional conception of childbearing women that I myself was seeking to contest.

Methods Employed

Questionnaires designed to identify the socio-economic, ethnic and other relevant characteristics of participants were used (Appendix F) after the main phase of fieldwork.

These were not originally in my research design. It became apparent after the first few interviews that I was lacking essential forms of information regarding the women. I had not devised any tool through which I could really know my sample at the level of their social, economic and cultural characteristics. This was an oversight in my initial planning. This issue was quickly rectified by the construction of the questionnaire which was then sent to women. A covering explanatory letter was sent with the questionnaire (Appendix G). Twenty-nine were completed and returned. The results of these questionnaires can be found in Chapter Four where their age, ethnicity and social class are identified and in Appendix H where I present a short biographical profile of the women which briefly describes the nature of their experience of pre-eclampsia.

Semi-structured interviewing was the primary method to collect data. Interviews were conducted on a face to face personal basis with eighteen of the women. Another five women were interviewed using the telephone. The same interview schedule was used for both types of interviews (Appendix 11). Solicited written accounts, guided by the thematic scheme of the interview schedule (Appendix 13), was a second method used to gather data from seven women. I had not originally planned for either telephone or written accounts to be used. Some women however wanted very much to take part in the research but various practicalities would have prevented this if it were not possible to include them in this way. Some simply preferred these alternative methods. I decided to be flexible with the manner in which I would collect accounts rather than risk turning away women who were interested and willing to participate. In total, seven women forwarded me written accounts. In terms of significant others, one husband forwarded me a written account and one man also forwarded me the diary he wrote during his wife's illness and up to the death of his baby son. Another husband was personally interviewed as was one of the women's mothers. Two other women's mothers sent me solicited written accounts.

The interview method has received much critical consideration given its status as one of the most widely tools of sociological investigation. The different types of interviews, their advantages and disadvantages and the wider issues of their reliability and validity have been reviewed (Kvale, 1996, May 1993, Fontana and Frey 1998 and Miller and Glasner 1997). The common basis upon which interviews are differentiated is that of their degree of structure and formality. At one extreme is the fully structured interview characterised by pre-determined questions presented in a standardised manner to all respondents. I chose not to use this approach as it does not lend itself to qualitative enquiry given its standardised and inflexible nature. Responses may simply reflect the imposed framework as revealed in the questions rather than the 'life world' of the respondent. At the other extreme lays the unstructured, sometimes referred to as depth interview. Marshall and Rossman (1995) describe it as being 'conversation like'. By not approaching the interview with a predetermined list of questions or established themes, this type allows the interviewee to frame and structure the responses.

The unstructured interview lends itself easily to qualitative inquiry given the intention to understand the participant's perspective. Initially I had considered using this type of interview. However, there were both practical and research specific reasons why I discounted it. In terms of the former, this type of interview is very time consuming both in its practice and analysis of consequential data. As a part time student, I had a restricted amount of time available. It necessitates very high level of interview and interpretive skills. As a student researcher I was less confident with using a method that demanded such skills and in particular the depth of data that I would only retrospectively be able to give some thematic ordering to. I wanted to explore a range of specific issues with the women. For example, their early perceptions of pregnancy and how they defined the early symptoms of pre-eclampsia. Given this, I needed an interview approach that enabled me to explore themes central to my research as I initially considered them, but without negating the

ability to follow through with issues as they emerged in the interviews. It was primarily with this in mind that I decided to employ the semi-structured interview.

The semi-structured interview is characterised by the researcher isolating beforehand certain areas which she wishes to explore with the respondent. Whilst ideas about possible phrasing and prompts may be identified on the schedule, the format is not one of pre-designed questions. How and when, and indeed even whether, particular themes are brought into the conversation may vary from interview to interview as an attempt is made to allow respondents freedom in their responses and the interviewer flexibility of questions asked and their ordering. My interview schedule identified four time periods: early pregnancy; that time when initial symptoms of pre-eclampsia developed; thirdly, when abnormality had been defined in some way; lastly, the post-pre-eclampsia time. Sub-themes were identified throughout these periods, including the support received by the medical profession and the women's understanding and response to the initial symptoms. Whilst the order of these themes was dependent upon the flow of the interview itself, I did strive to cover them all, as well as allowing time at the end for the women to tell me anything else about their experience that we had not covered (Appendix 11).

The nature of the interviews undertaken for my research was influenced by feminist critiques of mainstream interviewing practices. It has been argued that such conventions equate to a research exercise whereby patriarchal ideological constructs of hierarchy, detachment and 'trust without reciprocity' from the researcher are produced (Oakley, 1981; Reinharz and Davidson, 1992 and Mies, 1993). For this reason, a specific style of interviewing has been promoted which tries to challenge such constructs and it is this that I attempted to adhere to in ways previously mentioned. The potential moral dilemmas, (i.e. of exploiting the resultant 'trust'), of this form have been considered from within feminism (Finch, 1993). My own experience suggests further a problem with assuming some degree

of reciprocity founded upon identification with all women and I considered this problem earlier. Despite assuming that a shared experience as a woman and as a previous sufferer of pre-eclampsia would allow me to relate to the women, for some it did not. There were aspects of their stories that I understood and perhaps even knew and undoubtedly this provided a basis for self disclosure and greater disclosure from them. However, I also found it hard to relate to some of the women socially. I simply experienced some as powerful in many senses and this reduced my confidence though as previously mentioned I found myself exploiting the inherent power as researcher to contest this.

Five interviews were conducted using the telephone and the same interview schedule. A recording device was used after seeking once more the women's consent to the interview being recorded. While, as previously mentioned, it was not my original intention to conduct telephone interviews, there are many benefits to this method, including the possibility of including a wider geographically placed sample and the increase in cost-and time-effectiveness. All three of these were certain advantages for my research. I did initially have some concerns over the quality of data that could emerge through this method. Telephone interviews are most often associated with surveys consisting of closed questions. Smith (2005) considered the advantages and disadvantages of the method including its use in qualitative research on sensitive topics. She notes the apparently conflicting evidence. However, my research confirms the conclusions of other work which has found little difference in comparison with face-to-face interviews (Quinn *et al*, 1980 and Sturges and Hanrahan, 2004). The only real difference found by the former research was a time reduction of three minutes with telephone interviews. The interviews in my research did not differ substantially in time or quality of data. The fact that some chose to be interviewed in this way is significant though this was something I did not directly explore with them. It may have been that the very 'faceless' nature of the method may have empowered some women to tell of their experience in a situation they felt more

comfortable with. For others, it was simply practicalities of time and geography that led to this method of inclusion.

The written accounts varied in length but most were between four and five pages. Writers were provided with a crib sheet (Appendix 13) which mirrored the interview schedule (Appendix 11). There is some research concerning the use of diaries, solicited and unsolicited though it seems to have been relatively neglected as a method in sociological research (Elliott, 1997; Jones, 2000). There is nothing explicitly on the use of solicited written accounts. This is a surprising absence I feel. Six women chose to share their experience with me in this way and it shared some of the practical advantages of the telephone interview as considered above. However, the quality and depth of data was limited in comparison to the other methods. This could well have reflected the sheer effort involved in writing such an account. Ultimately, it was a reflective piece of writing and although they were provided with a crib sheet, my absence during its construction, unlike the interview methods, meant I was unable to prompt where necessary. When comparing the written accounts with the diary offered to me by one woman's husband, I can see the greater usefulness of the diary method. However, as pre-eclampsia for the women in my study was initially unpredicted, the method would not have been viable though I do believe that the solicited diary method could have proven useful in researching the experiences of women entering subsequent pregnancies.

Ethical Considerations

When I planned and conducted my research, I was formally required only to comply with the British Sociological Association's 'Statement of Ethical Practice'. The Open University then instigated a Human Participants Materials Ethics Committee (HPMEC) as

the body through which all subsequent planned research would be presented for ethical approval. Although retrospective ethical approval was not available, I decided to forward the Chair of the Committee the necessary completed ethics forms (Appendix 2) and the relevant evidence in order to seek an opinion. In this section of the chapter, I begin by considering my interaction with the BSA guidelines; I discuss the way in which wider feminist ethical principles also informed my work. This section concludes with a consideration of the response of the Chair of the Ethics Committee.

The BSA statement is intended to provide the sociologist with guidelines to inform rather than replace upon their own ethical judgements. The guidelines cover the need for 'professional integrity', (isolating for example the need to report findings accurately), and the nature of researchers' responsibility to their sponsors. In relation to respondents, the need to secure their physical, social and psychological well-being, the need, ideally, to gain their informed consent and the need to ensure their privacy and anonymity are clearly identified. With regard to the present research these ethical issues were addressed reasonably easily, although, as I shall later indicate, these are not the sole concerns which should be understood as ethical given the nature of my research.

Informed consent was promoted at various stages of the research. When potential participants contacted me, I forwarded information outlining the topic of the research, my status as a research student and the institutions through which the research was being monitored (Appendix 4). Before the formal commencement of the interviews, I asked respondents again whether they would like me to explain the nature and purposes of the research. Consent for the tape recorder to be used during the interviews was sought prior to and immediately before the interview. Respondents were told that the tape recorder and/or the interview itself would be stopped at any point if they so wished. Every interview

concluded with the respondent being given the opportunity to ask me any questions about the research. Questionnaires distributed after the interviews clearly stated the reasons for their distribution, both on the questionnaire itself (Appendix 7) and in the covering letter (Appendix 6). Contact with the women's partners/husband/mothers was initially sought via these original respondents to ensure that they would not object to such contact being made (Appendices 8 and 9). Again, with these 'significant others' the nature of the research was fully explained in both verbal and written form (Appendix 10). Formal thank you letters forwarded to all respondents included a form which was used to indicate their consent or otherwise to my making any possible further contact (Appendix 5).

Letters and verbal exchanges prior to the interviews and the forwarding of questionnaires and covering letters for the written accounts made very clear that all contributions would be treated in confidence and that respondents' anonymity was secure.

The BSA Guidelines also indicate the need to safeguard the general well-being of respondents. Kvale (1996) identified the consequences of the interview upon the interviewee as an ethical issue. Given the particularly sensitive nature of my own research topic, this was a major concern for me. What would be the consequences of talking about what is often a traumatic experience on my respondents? Whilst all potential interviewees were made aware of my concern with the social and emotional consequences of pre-eclampsia, I could not predict their reaction in the interview situation. On the one hand, I felt that, as a previous Local Contact for the charity Action on Pre-eclampsia, I was personally equipped to aid and support women. On the other hand, I could not arrogantly assume this, given that I had not yet had great experience of the interview situation in relation to pre-eclampsia. I therefore decided that I should enter each interview situation with details of relevant support groups and help lines that I could offer women access to.

The feminist critique of mainstream research practices has resulted in a new conception of the ethical dimensions of social research. Identification and empathy become redefined as necessary and positive aspects of the researcher-respondent relationship. Trust is considered as one positive consequence. With regards to the latter, the exploitative potential of respondents 'trusting' the researcher has also been identified by feminists. For example, Finch (1993), in recognising the fact that women self disclose more to feminist researchers, writes:

‘I have also emerged from interviews with the feeling that my interviewees need to know how to protect themselves from people like me.’ (p173)

Information can ultimately be used against the interests of women. Exploitative relationships based upon a refusal to reciprocate are rejected by feminist researchers. Traditional strategies of interviewing have been criticised as unethical insofar as they replicate and therefore reproduce a masculine model of society. Oakley (1981) criticises the notion that the interview is simply a one way process whereby information is received by the respondent, but the researcher must not reciprocate. Respondents are, within this conventional approach, rendered as mere 'objects' of research and the interview is devoid of all personal meaning. Such approaches reflect patriarchal ideals of hierarchy, detachment and trust without reciprocity. I also identify the issue of reciprocity and the personal identification which it often presupposes, as an important ethical dimension to my research. This is because it presupposes a more egalitarian relationship. My intention to promote such a relationship with my respondent stems from my rejection of notions of 'distance' and 'hierarchy' which are bound up with patriarchal ideology. It also stems from the nature of my research which, in my opinion, demanded such equality. I was expecting women to share with me an experience which caused both physical and emotional distress.

A manner of objective detachment and refusal to engage, if requested, in my own personal biography, would not only have breached such ethical tenets, but would have also made it much more difficult for the respondents to view me as someone whom they could 'tell their story to'. I therefore decided that, should I be asked questions myself, I would answer them as truthfully and honestly as possible. However, as previously considered, the actual practice of interviewing at times problematised the reality of such ideals.

The ethical dimensions of social research which feminists have isolated and considered in their research practice also include that of the *purpose* for which research is conducted. Westcott (1990) argues that women have increasingly become objects of knowledge to exploit. This will continue, she argues, until we stop perceiving the aim of research as simply that of accumulating more knowledge. Rather, research on women should have the wider intention of improving their conditions of existence. The call is therefore to embrace an ethical dimension to feminist research, which provides not knowledge for the sake of knowledge, but the production of knowledge with the intention of promoting women's interests. Research should deliberately become part of women's liberation and be couched within the political context of women's oppression (Mies, 1993). My own research began, and has been continuously defined by the need not simply to acquire a knowledge base concerning women's experience of pre-eclampsia, but, if necessary, to provoke academic and policy enquiry into the construction of alternative models of maternal health care and support. These are, for my research, ethical concerns as significant as those more commonly promoted.

As mentioned earlier in this section, when I began my research, The Open University had no formalised ethical procedures. Since then the Human Participants and Materials Ethics Committee has been established. The response of the Chair to the completed ethical approval application (Appendix 2) was as follows:

‘I have looked through these documents and consider that the protocol and additional documents indicate that student researcher has complied with the requirements of the BSA and broadly with the expected ethical standards of the Open University Human Participants and Materials Ethics Committee’. (Appendix 3)

The Chair identified however three points that I would have had to consider if I had been seeking formal approval. The information that I had distributed to respondents did not formally identify a third party who they could have contacted should there had been any issues that could not be resolved by me alone. The Chair also noted that I needed to state explicitly that the respondents could have withdrawn from the study at any point. I do actually feel this was done. For example, not only did my letters state this (Appendix 4) but I repeated this verbally before the actual commencement of all interviews. However, I did not explicitly state that all their data would then be destroyed. The third point raised was the need for a consideration of the risks involved regarding location of interview. I did engage in this at one level insofar as someone was always informed of the location and time of any interviews conducted face to face. This was never documented however in any formal risk assessment.

It is obvious from the previous points that there are improvements that could have been made in terms of making certain forms of information more explicit and in terms of engaging more rigorously in a risk assessment. I do feel, however, that generally the research design was ethically sound and that I in fact entered it with a wider conception of ethical dimensions than that required by the two formal bodies.

Data Analysis Procedures

This section describes my approach to making sense of the data collected. The procedures do not represent an unproblematic conformity to a specific qualitative analysis strategy, but rather an approach arrived at after being immersed within the relevant methodological literature. For the sake of clarity therefore I describe the process of discovering this logic. The section is completed by a description of the actual practical procedures involved in the analysis.

The purpose of my research was, through an exploration of how women make sense of their experience, to produce explanatory ideas, by comparing like with like, about the conditions which provide the 'local' contexts within which women socially and emotionally experience pre-eclampsia. I wanted to produce ideas which would move beyond description to possible explanation. I knew I would have to move towards the latter if I were to generate ideas for improving the experiences of women. I wanted to understand both the particular surrounding conditions and 'local context' within which each woman found herself and their more general patterns as they might be generalised across accounts. However, in order to produce some kind of explanatory account of all my respondents' experiences, I would need to search out, not only what was similar but what was different. The latter would then need equally to be explained. Comparing and contrasting was therefore inevitable but I wanted to do this without losing altogether the individual voices of women.

My initial difficulties with finding an easily accessible technique made sense when I discovered that there was a gap in the literature that posed particular problems for a novice researcher (Bryman and Burgess, 1994). This lack of clear guidance for the beginner researcher is explained by Doucet and Mauthner (2002) in terms of some of the problems

in articulating the details of the analysis process. They suggest for example that the early stages of analysis are 'messy', 'confusing' and 'uncertain' and this is simply difficult to articulate. Furthermore, qualitative analysis makes very obvious the subjective and interpretive nature of the analysis process. It seems to me that a certain amount of courage and reflective clarity is required to reveal the basis of ones interpretations. Indeed, Doucet and Mauthner suggest that the increasing use of software for analysis may in part reflect a need for the security and air of objectivity which computer usage can confer.

Miles and Huberman's (1994) sourcebook of techniques for qualitative analysis provided some clarity. Their idea of analysis consisting of three 'flows of activity', data reduction, data presentation and conclusion drawing, appealed to me. Likewise, their tactics for generating meaning, (e.g., searching for patterns, comparing and contrasting, counting), provided me with an early understanding of making sense of all the data. However, the sheer number and sometimes complex presentation of the techniques was confusing and I lacked the confidence to delve in and extract techniques without having a clearly defined approach to data analysis.

Tesch (1990) provided a useful overview of the many strategies available to the qualitative researcher, categorised on the basis of what researchers considered as their underlying interest in conducting the research. If one was interested primarily in language and its content or the way in which it was culturally reflective, then content analysis and structural ethnography were possible strategies, respectively. Content analysis consists in its classic form of researchers constructing categories relevant to their research questions and then searching for instances of this within the text. If used by qualitative researchers however, categories are allowed to emerge relatively free from a pre-designed list. Structural ethnography involves the analysis of the language within a text in order to understand the cultural context which they are assumed to represent. Tesch isolated

grounded theory as appropriate where the interest is less with language *per se*, and more with isolating patterns within social phenomena and experiences as they emerge from individuals' accounts. Given my early ideas, I was seeking an inductive approach to data analysis, one based upon discovering regularities which could be categorised so that the relationship between them could be explored. It would be these relationships that would form the basis of potential explanations and theory building. This process would not be divorced from women's stories but rather grounded in their words. It seemed as though the grounded theory approach would enable me to pursue analysis in a manner reflecting my original ideas of what I hoped to achieve.

I had initially encountered Corbin and Strauss' 'remake' of grounded theory, (the original being established in 1967 by Glaser and Strauss), in an overview presented in Denzin and Lincoln (1998a). From this overview, I understood grounded theory to be not simply a strategy for data analysis but rather a general methodological approach. The collection of data and its analysis are inseparable and this is made evident in the notion of theoretical sampling. Ongoing concept generation forms the basis for further sampling and data collection, the intention being to explore varieties within and deviations from the emergent categories. My own research had partly reflected this strategy insofar as a sample of accounts generated by women's significant others had been included on the basis that their experience was emerging from the data as important. Generally however, data collection and analysis were not so intertwined in a manner to have labelled the research process as representing grounded theory. I did believe however that some of its associated strategies might prove useful. Corbin and Strauss' *Basics of Qualitative Research* (1998) enabled me to comprehend concept generation and comparison, so as to construct categories and searching for their varied properties, (attributes), and dimensions, (the different locations on a range which a property might be found). The process of constant comparison provided me with a general approach with which to build categories within

cases and to develop and /or redefine them across cases. The notion of the conditional matrix was also useful. I had wanted to understand both the 'micro', (for example, the informative role of friends and family), and 'macro' conditions, (for example, discourses of pregnancy), in women's experiences of pre-eclampsia. However, I was confronted with various problems. As mentioned previously, theoretical sampling did not characterise my data collection process. Furthermore, whilst I might have gained a general understanding of some of the strategies promoted for data analysis, I could not claim that my research design completely conformed to grounded theory principles and hence my approach under the heading of grounded theory. I was competent in generating concepts and categories in the manner suggested but when I attempted to reassemble data, and isolate relationships, I found the presentation of the strategies awkward in their complexity.

According to Green (1998) some researchers have a tendency to routinely claim that their data was analysed using grounded theory without making obvious their use of such a strategy. Green suggests the readiness of some to associate themselves with grounded theory is an attempt to improve the credibility of their research. I found the expression of many of the strategies bewildering and had found myself so concerned with rote learning the procedures that I effectively stopped thinking about my data. Techniques designed to assist the analysis process, began to be experienced by me instead as barriers. The general issue about technique learning hindering thinking is one isolated by others. Melia, (1996) argues that in grounded theory:

'...the procedures are getting in the way; the technical tail is beginning to wag the theoretical dog.' (p. 6)

According to Robrecht (1995), the increasing complex procedures:

'...begin to divert attention from data towards the operational steps

prescribed by the procedures.’ (p. 2)

Further contributions (Melia, 1996 and Kendall, 1999) revealed tensions in the theoretical underpinnings and an apparent paradigm shift illustrated by the differences between Glaser and Strauss (1967), the original version and the later one exemplified by Corbin and Strauss (1998). Anells (1996) has also isolated dimensions of this shift. The earlier versions stressed a ‘reality’ and a ‘truth’ that was knowable. Later versions focus on a more relativist concept where it is never possible to explore the ‘truth’ but simply to consider differing versions of it. Earlier versions suggested that the method had an independent existence from the researcher, later ones that the researcher is intimately tied with the method and this is expressed in the encouragement of researchers to draw upon their own experiential knowledge when collecting and analysing data. Anell also claims that Corbin and Strauss’ later version, where they give consideration to the macro social factors as they impact upon social interaction, (through the use of the conditional matrix), is a departure from the theoretical basis of classical grounded theory in symbolic interactionism. I found these articles useful. I had been aware of the symbolic interactionist basis of grounded theory. I had been concerned with using an approach whose theoretical origins suggested a focus on the interpretive and negotiated nature of meaning only. I also wanted to explore the origins of meaning within the wider social structural context. Realising the way in which Corbin and Strauss’ version moved towards a direct need to account for possible macro considerations was therefore useful.

A further query in my mind was the relationship between feminism and grounded theory. Wuest (1995) asserts a reasonably comfortable relationship between the two. Grounded theory regards individuals’ subjective interpretation of the social world as sources of knowledge. Similarly, feminism promotes women’s voices as valid data and

women as the experts on their experience. Both feminism and grounded theory recognise the subjective positioning of the researcher in relation to the research and how this can impact upon the analysis process. Wuest also seems to suggest a way in which the ethos of grounded theory may support the feminist researcher in attempts to avoid falling into the trap that feminists themselves critique: promoting the primacy of the researcher's interpretations. The example is given of researchers reducing women's understandings to 'false consciousness'. Grounded theory demands an ongoing conscious effort not to fit the data into prior assumptions which may stem from one's perspective. She suggests that:

'In a feminist grounded theory study, knowledge of feminist theory may influence what is observed and the discussion topics, but only concepts that emerge from the resulting data *will enter the resulting theory* [my emphasis]. The emerging theory is driven by the data not by the theoretical framework.'
(p.5)

Wuest's article brought me a little closer to thinking about the relationship between feminist research and the analysis process. I began to think more critically about the assumption that it was possible to analyse data purely inductively. Firstly, whilst on the one hand, induction makes sense if one wishes to remain close to women's words; I do not believe that concepts and categories simply emerge. At some level they are taken from the text and therefore some decision has been made. Induction is a worthy ideal but pure induction is impossible. It makes sense to admit to that fact and then make central to the analysis process the revelation of these decisions. Wuest suggests that reflexivity will help to bind the 'union' between feminism and grounded theory. It will help the feminist researcher avoid imposing feminist ideology onto the data. However, given my point about the impossibility of concepts emerging free of a decision making process, this reflexivity might be better used. Rather than engaging in it to avoid wearing the glasses of feminism, it should be a process of defining the style and lens strength of the glasses. Denying the decision making process at the level of concept construction by hiding behind the ideal of

pure induction, is to disguise this part of the 'labour process' through which knowledge is produced (Stanley, 1990). The concern for the research process in this way reflects a refusal to accept a distinction between 'what is known' and 'the act of knowing'. Such distinctions reflect the dualism which often characterises 'male-stream' approaches, (evident in the following dualisms: researcher/researched; objectivity/subjectivity). For Stanley however, the distinctive feminist contribution with revealing the 'labour process' of knowledge production is that it makes evident the conditions of feminist 'being': the experience of revealing and contesting perceived oppression.

A major problem with clearly articulating the process of analysis is, of course, the anxiety produced by the thought that you 'might not be doing it right'. I have come to the conclusion that the whole notion of 'doing it right' according to someone's 'guidebook' can be a dangerous concern. Qualitative analysis is an interpretive process, one surely bound to one's own part in the data creation process and therefore necessarily unique in important respects. This does not imply that it is not good sense to utilise some of the general strategies advocated by those that articulate them. It simply means that it is important to keep hold of the data by not losing sight of the fact that one is subjectively bound up with it and therefore well placed to interpret it. This necessarily demands that the relationship which the researcher has to the data is revealed and critically reflected upon. My attempt at this is in part represented by the inclusion in this thesis of my own account of pre-eclampsia and a consideration of its significance for the research process. Earlier in this chapter I also revealed my intellectual preferences regarding social enquiry and the way in which ideals concerning the interview process were more difficult to put into practice because of my own sense of inferiority. Furthermore, I have revealed the process I went through to establish a way of making sense of data and, in doing so, my own ambiguities regarding the process.

I believe one can justify analysis strategies without having to align with an established procedure to be rigorously conformed to. I have come to this conclusion after realising, on reflection, that my earlier search for an already legitimated strategy was the beginnings of a process whereby I would become alienated from the very data which I had been party to creating. Without having the security of a known and accepted strategy, I lost confidence in my ability to become immersed within the data. I decided to learn from some of the strategies advocated by Corbin and Strauss' version of grounded theory and proceed with an approach which can generally be defined as a form of grounded theory rather than grounded theory *per se*. According to Bryman and Burgess (1994) it is questionable whether grounded theory is ever used in its entirety. Like the contributors to their book, it has provided me with a 'general disposition' towards data analysis (p.220). I do not seek to provide a fully integrated theory, the intention of grounded theory. Instead my concern is with providing a detailed account of the patterns in the relationships between emerging categories with the intention of possibly isolating more general themes within which many accounts can be 'made sense of'. I draw back from attempting to present a fully integrated theory. The reason is that data collection and analysis were not so intertwined to make me confident that any resultant theory had emerged through the purposeful sampling of all possible variations. For example, what would the impact be upon category development if I sampled women who were without a partner throughout the pregnancy and birth? I cannot answer this question. My category construction is therefore limited to drawing from a small self selecting sample of women, rather than from an ongoing purposeful process of theoretical sampling as advocated by Corbin and Strauss.

Building in as many variations as possible expands the explanatory power of a category and therefore makes for a good building block to theory development. My 'blocks' are much 'weaker' and therefore do not provide so well for a theory of the experience and consequence of pre-eclampsia. However, I agree with Rose and Webb (1998) who argue

that:

‘Accepting the limitations of the interpretive process does not, however, imply that it is not a useful interpretation of the experience.’ (p.561)

The strategies identified below reflect my attempt at providing a useful interpretation of the women’s accounts. Using these strategies I attempted to generate concepts and categories inductively in order to seek possible explanations through isolating the relationships between categories. The strategy of constant comparison is a basic feature. The process of analysis is such so that ‘in case’ and ‘across case’ understanding and explanation is sought. Theoretical sampling has not been a core feature of my data collection process and therefore I cannot claim allegiance to grounded theory in this respect. The analysis process also reflects the need for reflexivity, not simply at the end of the analysis process, but throughout. This reflects a desire to reveal the ‘labour process’ as it is worked at the level of analysis.

Strategies

Initial coding was conducted through a sentence by sentence reading of accounts. These first codes were descriptive codes only. The codes were written and defined on small pink cards. Segments of text to which the code referred were copied onto larger blue cards and clipped together. The coding of each account was based upon a comparison with existing codes which are then ‘built upon’ or new ones established. For each interview the codes (pink cards) were literally laid out to reflect the organising principle of conditions (macro, micro), consequences and action/interactions, (as both conditions and consequences). What belongs where was decided mainly by referring again to the actual text and women’s

words. Phrases such as 'and therefore' indicate consequences; and 'because I felt...' indicate conditions. Where it was not obvious at the level of women's words, a process of interpretation had to occur. When the cards were laid out, a process of comparison was undertaken between codes within the different 'arenas' of the organising principle. From this, categories were established which were not simply descriptive but more analytical. For example, rather than 'all codes to do with gaining information', codes were categorized as 'lay referral' or 'professional information monopoly'. These categories were labelled and defined on large white cards. The relevant codes and text segments were attached.

Relationships between categories were isolated and these were documented as 'relational statements'. Relationships were sought not just within the different arenas of the organising principle but importantly also between them. In this way, ideas could be expressed as to how particular conditions impact upon women's social and emotional experience of pre-eclampsia (Corbin and Strauss, 1998). These relationships were also visualised through cognitive mapping (Miles and Huberman, 1994)

The above process was conducted with each account, the main strategy being comparison, drawing out contrasts with existing concepts and categories. This not only built variability within categories but also allowed for further concept and category development. To search for patterns across individual accounts, the isolated relationships between categories were compared and contrasted. The 'relational statements' and 'cognitive maps' produced for each account aided this process. The interpretive process was constructed around the following types of questions:

How often is A seen as relating to B?

What is the nature of this relationship? For example, is it a condition or a consequence?

What are the various ways through which this relationship is expressed?

What conditions are present when this relationship emerges?

In accounts where A does not seem to be related to B, what are the specific conditions which may account for such differences?

Answering such questions through detailed reference to women's words as they are represented within concepts enabled me to present explanatory narratives, inclusive of statements like 'Under these conditions', '...is most likely to occur when...' and 'When these set of events are present....'. The result was therefore an analysis that enabled me to make a number of general and explanatory statements whilst remaining loyal to the words of those who shared their experiences with me. This analysis will be presented in the following four data chapters.

I approached this research with a set of assumptions regarding what was important in the topic, the manner in which data collection and analysis should be carried out and the purpose that the research should serve. These assumptions emerged not only from a perspective influenced by feminist theory, but from a personal and traumatic experience of the very subject matter of my research. I have attempted in this chapter to outline these sets of factors and to consider their significance in terms of the research process. Though I have suggested some possible methodological limitations with my research, it is in Chapter Nine that I present a more detailed evaluation.

The following four chapters are dedicated to presenting the results of my analysis of the primary data obtained. Chapter Four considers the way in which the women's ideas about pregnancy and birth were constructed and the sustaining of these ideas even when symptoms emerged to suggest deviation from initial expectations. In Chapter Five, I reveal the subjective and physical experience of pre-eclampsia as reflected by my respondents. In recounting their experience, the importance of those family members who were with them during their illness was evident and therefore Chapter Six provides an initial exploration of

some of their 'unheard voices'. The final data chapter, Chapter Seven, explores the consequences of pre-eclampsia and women's views on improvements to the care received.

Chapter Four

Constructing and Sustaining Childbirth Expectations

This is the first of four chapters concerned with presenting the analysis of the primary data gathered through the interviews and written accounts. It considers the way these perceptions were constructed and the way in which these were then initially sustained when problematic symptoms began to emerge. To explore these issues the interviews and guide for the written accounts (Appendix 13) included themes such as 'early perceptions' and 'initial symptoms'. They were explored through various open-ended questions such as 'how did you view pregnancy before experiencing pre-eclampsia?' and 'describe the early physical changes you experienced and how you responded'. The way in which women initially perceived pregnancy was explored with all women. As mentioned above, some had experienced the illness in their first pregnancy only. Others had developed pre-eclampsia in further pregnancies and some women became ill in later pregnancies after experiencing one or more with no such complication. For all these women, I was interested in those early first pregnancy thoughts and assumptions. Given my concern to understand the impact of different models of childbirth upon women's experiences of pre-eclampsia, after exploring their general expectations I directly asked women about their understanding of and response to the natural childbirth model of pregnancy and birth.

Chapter Two showed how some feminists have promoted the natural childbirth model as a challenge to medicalised maternity care. I was therefore interested in exploring the extent to which the women in the sample had embraced such ideas and the implications of

this for their experience of pre-eclampsia. The responses of the women demonstrate the lack of any simplistic acceptance of the model.

How then are we to make sense of their early expectations? Later in this chapter, three social processes are identified which mediate the influence of both natural childbirth and medicalised notions upon women's early perceptions and assumptions. In identifying these processes, it will be suggested that the assumption that the nature of the natural childbirth model can render it a challenge to the medical model is particularly problematic when one considers how these two models are expressed through women's experiences of problematic pregnancies. The current chapter ends with an exploration of the early consequences of women's expectations. I show how emerging symptoms of abnormality were normalised by many women and how this demonstrates the impact, at this point, of women's embodied experiences and referral networks in mediating the influence of the natural childbirth model. This consideration forms a bridge between this and Chapter Five, where I explore the experiences of women once diagnosed and hospitalised with pre-eclampsia.

The Normality and Naturalness of Pregnancy

When asked to reflect upon their early expectations, nearly all of the women had identified pregnancy and birth as in some way normal and natural phenomena, terms often used interchangeably and essentially used to convey the notion that these reproductive processes, for them, were devoid of any potential significant risk. Women's accounts of how they had perceived pregnancy initially revealed an apparent absence of any concept of potential adverse outcomes. This can be explained in terms of the seeming dominance of pregnancy constructions defined by normality and naturalness. The different ways in which

this dominance was expressed warrants exploration. In doing this, I shall show how these actually suggest not simply the influence of natural childbirth ideas but also wider cultural conceptions of pregnant womanhood and motherhood and the increasingly commodified experience of pregnancy and birth.

There were four main ways in which women expressed the expected normality and naturalness of their pregnancy; these were to do with its assumed 'ease', the acceptance and perceived 'worthiness' of pain, overall positive physical imagery and the expected 'happiness' surrounding pregnancy and birth. Turnings first to 'ease', a variety of different expressions are used to convey this idea including the expectation of birth being 'plain sailing' or a 'doddle'. Pat suffered from pre-eclampsia in her fourth pregnancy and spent three days in intensive care. She recalled her earlier attitude towards the fourth pregnancy.

'...everything [was] going to be straightforward. There will be no complications or anything...'

Although she had been aware of pregnancy complications, she concluded her own pregnancy was normal. For some women 'ease' was derived from the sense of pregnancy as being commonplace. Mags experienced pre-eclampsia with her first pregnancy which necessitated a caesarean and her stay in hospital for ten days. Before this experience she had assumed the 'ease' of pregnancy, thus pregnancy was just a normal event which *'...thousands of women have done before'*. Arms (1994) writes of the unnecessary fear of the physical processes of childbirth which has been produced through medicalisation. Instead of fear, she suggests that women should embrace the reality of their physical and embodied power as women to manage these processes with confidence. For women such as the above then, has this fear been defeated through recognition of the ways in which its naturalness, defined by its commonality and ease, renders it manageable? It is impossible to arrive at a definite answer to this question since it was not directly examined. However,

the expressions of ease in some of the accounts might suggest a belief in the manageability of it.

A second way in which the expected normality and naturalness of pregnancy was expressed by the women was in their conceptions of the pain of childbirth. Physical pain is generally considered as evidence of some kind of abnormality or ill-health. In contrast to pain as a signal of trauma or ill health, childbirth pain is portrayed in western cultures as substantively different. In the medical model it is constructed as something to be controlled and a negative part of childbirth and in the natural childbirth model as something to be positively controlled and experienced as work. The pain of childbirth therefore illustrates the sociological consideration of pain as socially constructed. Williams and Bendelow (1998) argued that the medicalisation of pain has led to it being narrowly conceived in terms of physical sensation. Drawing upon insights from the sociology of the body and emotions, they developed a phenomenological approach to pain which conceptualises it beyond only the physical. Pain is intertwined with emotions and it is given cultural meanings and is therefore culturally shaped. This is evidenced in the data from the women's accounts of their early perceptions of childbirth and their considerations of pain. Later in this chapter, therefore, I will show how certain types of pain were normalised and in Chapter Five the different interpretation and experience of the pain associated with pre-eclampsia is considered. The socially constructed nature of pain is, however, also made evident in women's early expectations of pregnancy and birth and is revealed as a product of the influence of competing childbirth models and the mediating influences of social factors. The pain associated with birth was a defining aspect of its normality and naturalness. However, there were in women's accounts differences in the nature of the association between pain and naturalness. Some women expressed pain as something that was necessarily part of normal childbirth. The following two reflections demonstrate pain as being something that is necessarily submitted to. Linda was in her early thirties at the

time of the interview. She had experienced pre-eclampsia in both of her pregnancies, with both babies being born by caesarean and requiring neonatal care. In reflecting upon the pain of childbirth, she implies that it is indeed part of normal childbirth and something to acquiescence to because of the 'reward' of a baby.

'I knew from all accounts it was painful, it was horrific, but my mother would say it was worth it in the end' (Linda)

For Mags, there would be *'pain, sweat and tears...but that was the price you pay for a baby...'* Such accounts suggest little accommodation to natural childbirth conceptions of the pain of childbirth. Its proponents write of pain as being something that is controllable, be it through physical exercises and or psychological training. Here we see, not a notion of pain as being managed, but rather as being necessarily endured. It is less something to 'take care of' and more something to 'put up with'. However, other women did conceive pain as not only necessary, but in some way worthy in the way that it is viewed in the natural childbirth literature. Terri was diagnosed at thirty-eight weeks, induced and suffered from liver and kidney failure requiring time spent in intensive care. Her experience of pre-eclampsia illustrates how the experience of pain was considered as indicative of success

'I wanted to have a natural birth, I did put it in my notes...and of course all that went straight out of the window. I did keep saying that I have failed after having a caesarean. I had failed myself because I wanted to go through, it sounds really stupid, I wanted to experience the pain.'

Her account appears to equate pain with a successful experience of childbirth, a rite of passage into motherhood, something that a successful mother's body would achieve. This equation of pain with success revealed greater accommodation to the natural childbirth model of pain. Terri's sense of failure was experienced, therefore, because of the loss of

opportunity to manage pain well. Her sense of failure indicates her association between 'normal' birth and necessary ('put up with') pain, the lack of experience of which created a sense of personal failure. In reflecting upon their early expectations, however, it is notable that none of the women articulated the possibility of serious complications which would lead some to experience physical pain associated with developing abnormality like that of epigastric pain, the pain caused by a swollen liver.

Physical imagery associated with an uncomplicated pregnancy was also a feature of some women's reflections on their early expectations. The naturalness and normality of pregnancy and birth was expressed in terms of the physical imagery associated with experiencing an uncomplicated pregnancy. Such imagery involved a positive construction of the bodily changes accompanying pregnancy. Linda, who as I have shown above, equated the naturalness of pregnancy with the necessity of pain, also spoke of the associated positive physical changes.

'...it was going to be like you read in the mags. Like I was going to bloom, my hair and skin were going to be looking good. I was going to have a lovely bump.'
(Linda)

Ellen's two pregnancies both resulted in the early birth of her babies due to pre-eclampsia. Her reflections on her early perceptions of pregnancy expressed a similar view to that of Linda. She said she had always considered pregnant women as:

'...having that rosy glow about them at home rubbing cocoa butter all over them and talking to it'.

Reflections such as these suggest the impact of wider conceptions than those available within the natural childbirth model. Instead, it might be argued that the cultural construction of the female body and specifically the pregnant body are significant in

making sense of these expectations. Whilst female bodily image and its relationship to female liberation has been explored (for example, Wolf, 1990), less research and commentary is available regarding bodily image and pregnancy. Jordan et al's (2005) research into body image post pregnancy, suggested that new mothers had variable concerns with body image, with some relegating it as unimportant in the context of now having children, for example. Others have commented on the contemporary celebration of the pregnant body (Cusk, 2003). Earle's (2003) research suggested that, contrary to other research findings which concluded that becoming 'fat' was less of a concern when women became pregnant; they remain concerned with body image throughout the pregnancy process. Such research is useful in identifying the wider cultural context within which some of the women in my sample developed positive notions of pregnant physicality. However, what this type of research has failed to directly explore is the ways in which these positive images represent 'normal' pregnancy and, crucially for the theme of this thesis, the consequences of this for those who deviate through pregnancy abnormality.

A fourth way in which the women in my research conceptualised the assumed normality of their pregnancies was in their expectations that these processes would result in 'happiness'. This expectation of happiness surrounding the childbirth process was for some expressed through the expected intimacy and peacefulness of their childbirth experience. For example, Lorraine believed that:

'...it (would) be all serene, peaceful and that he would be born and given to me'

This expectation was thwarted by the diagnosis of pre-eclampsia at thirty-five weeks, an emergency caesarean and her having to be hospitalised for a week. Her early assumptions regarding pregnancy and birth were devoid of any possibility of obstetric emergency and in this respect express the ideals of the natural childbirth model, whereby, as I have suggested

in Chapter Two, the psychosocial experience of childbirth is promoted and possibilities of problematic pregnancies and births marginalised. Other women also mentioned in their description of their early expectations a picture of birth with 'happy' endings. Suzanne conceived a picture of being handed a healthy baby whilst those around expressed their happiness at the event. Instead, Suzanne's babies in both of her pregnancies would require neonatal care as a consequence of her experience of pre-eclampsia. Mags described her expectations of being joyous after the hard work of giving birth. What, however, is interesting with these previous two accounts is the association made, albeit briefly, between such 'happy environments' and (western) commodities associated with pregnancy and birth.

*'...hearts and flowers and stars. All lovely stuff. You would have your baby. It would be placed on your tummy, nice round cheeks, everyone grinning'.
(Suzanne)*

*'...decorating nurseries, fluffy bunnies, followed by pain, sweat, tears but complete elation that you have got this wonderful baby'.
(Mags)*

In understanding the development of women's early expectations, ideas beyond those available within different childbirth models are significant. Thus, it could be suggested that the close association between expected normality and commodities such as 'hearts and flowers' and 'fluffy bunnies' expresses the increasing commodification of women's reproduction. This has been explored by Taylor (2000), specifically in relation to the use of routine ultrasound. Arguing that the pleasures of consumerism for mothers-to-be has contained resistance to their relegation as 'workers' in a medically managed labour process, Taylor suggests that buying for the foetus has increasingly been defined as an act expected of good mothering. Whilst consumerism seems to encroach upon Suzanne's expectations of a happy normal birth in the sense of the presence of '*hearts and flowers*', this reflects less a process of consuming for the foetus and more a consuming to construct a

'romantic ideal' of pregnancy and birth, something not considered by Taylor. It might be suggested that this reflects a cultural ritual for successful birth outcomes intertwined with implied love between the parents.

In terms of my fundamental concerns, whether these expectations be characterised by consumerism or romantic ideals, they are constructed through a marginalisation of the possibility of serious problems. The expectations held by these women of a pregnancy and birth defined by the occurrence of 'happy events' were never fulfilled. My intention here however is not to attribute this unfulfilled ideal only to those who suffer serious complications but rather to simply claim it as one facet characterising their experiences. For example, Suzanne's pregnancy experience would be characterised by emergency medical intervention, and fear that *'if (she) slept (she) would die'*. Mags would become *'completely traumatised'* through her experience of pre-eclampsia.

Whether a positive image of the changing physicality of the pregnant woman, an ideal of the social and physical environment within which these reproductive processes would occur, an assumption of its normality defined through its commonality or a perception of the pain of birth as being rooted in its inevitable natural condition, these expectations were devoid of any sense of the serious complications of pregnancy. Bella had no previous symptoms of pre-eclampsia. At forty weeks she went into labour and experienced two eclamptic seizures. As Bella explained when reflecting upon her early perceptions of pregnancy:

'...you don't associate dying in the middle of having you know, a perfectly healthy baby growing inside of you'

The women's experience of pre-eclampsia would shatter these expectations. The consequences of this are considered in Chapter Seven. In attempting to understand these

expectations I have argued so far that they reflect not simply natural childbirth notions, but also wider cultural processes such as the construction of pregnant womanhood and successful motherhood. Nevertheless, it could be argued that these processes themselves reflect the construct of pregnant normality and the silence concerning abnormality and this, as argued in Chapter Two, is a defining feature of the natural childbirth model.

In the following section I explore women's understanding and attitude to the natural childbirth model directly. The previous consideration has been of their expectations as expressed in response to questions like 'how did you view pregnancy and birth when you first became pregnant'? However, to identify further their assumptions and ideals, I decided to explore directly what they understood by natural childbirth and their response to it. To what extent, when asked directly, did they embrace this model's central ideas? Are there tensions between the expectations considered above as they emerged through their general reflections, and their response to the model? These are some of the questions which I now explore.

Natural Childbirth

Natural childbirth can be understood as an umbrella term encompassing a wide range of techniques for the non-medicalised management of birth, a management rooted in women's own ability to control their own body during the birthing process (Moscucci, 2003). This is antithetical to medical intervention, be it anaesthesia, episiotomies, or caesareans and the medical context of the hospital. Chapter Two considered its expression amongst childbirth educators and the way in which some feminists had promoted it as an alternative to medicalised childbirth. Women in my research had spoken or written about their early image of pregnancy and had employed notions of natural and normal

interchangeably. Natural childbirth ideals seemed to influence, as considered in the previous section, some of their ideas. However, whilst most women entered their own pregnancy with a notion of its normality and naturalness, in speaking or writing of their thoughts specifically on natural childbirth, it is clear that this meant different things to different women and was not related easily to the prevailing model of natural childbirth as espoused in the literature.

I have identified two ways in which women expressed their ideas about natural childbirth: natural childbirth as 'home birth' and as 'freedom from intervention'. Whilst both of these represent some fundamental aspects of the natural childbirth model, some women's accounts revealed a degree of dismissal of such ideas, variations in what actually was considered as constituting a natural birth and apparent tensions between their responses to its ideals and their earlier expressions of pregnancy expectations.

Natural childbirth as home birth

Some women defined natural childbirth in relation to a non-hospitalised birth and embraced it.

'The only thing I would have liked is a home birth...I don't know perhaps [it's] more romantic. I guess in my mind bringing a child into the world in a less clinical environment, and to be in labour in the comfort of my own home rather than pacing up and down wards...'
(Mags)

Three women rejected the notion of natural childbirth, insofar as this was seen as comprising a home based birth. For example, Joanne who experienced pre-eclampsia at twenty-nine weeks, her baby requiring three weeks of neonatal care, rejected home birth on

the basis of being fearful about the birth process and of equating it with a political stance that she herself rejected.

'I'm a wimp. When I found out I was pregnant I thought, shit, I've got to give birth to this thing. No, it didn't even occur to me to have a home birth or anything like that...home birth I see as being for your looney left. As soon as I found out that I was pregnant the doctor said hospital birth and I completely agreed but then I have lived twenty five years in Camden Town and I had looney left shoved down my throat.'

Lorraine rejected home birth on the basis of safety.

'I wasn't interested in it really. I had been in hospital quite a few times with my ears so I wasn't unnerved about being in hospital at all. I was completely the opposite, I felt quite safe in there. If something was to go wrong, if the chord was round the neck....As a matter of fact when she was delivered by caesarean section she had the chord wrapped around her neck twice. So afterwards that was another thing I thought...maybe if I had gone through with natural childbirth she would have died.'

Both of these women had, however, expressed expectations of pregnancy which could be considered as expressing some aspects of the natural childbirth model. Joanne, for example, had assumed the 'ease' of pregnancy, describing it as '*a right doddle*' but given what she then stated in relation to the natural childbirth model, it would seem that such an expression of 'ease' is only 'available' against the backdrop of the legitimacy of the medical model, especially what she assumed it might offer in terms of alleviating her fear of childbirth, and a rejection of the assumed ideological basis of natural childbirth. Lorraine had described her early assumptions of pregnancy in terms of expected '*serenity*' governing the birth and post birth environment. Devoid of the expectation of obstetrical intervention and expressed in terms of emotional intimacy, it could be suggested that Lorraine's expectations expressed perceptions of birth emerging from the natural childbirth model and yet, like Jo, when asked directly about this model, she rejected it.

This apparent tension can be explained, I suggest, by drawing upon the work of Arney and Neill (1982). In their analysis of the changes in obstetrics, they argue that the threat of natural childbirth was averted through obstetrics reformulating so as to directly embrace the two dimensional nature of birth promoted by it. The promotion of subjective dimensions of birth promoted by natural childbirth increased the power and control of obstetrics over women by making all aspects of their being visible. I suggest that the accounts of Joanne and Lorraine provide a lived illustration of one consequences of this. That is, whilst expecting a childbirth experience defined by ideas emerging from natural childbirth, like that of its manageability for example, these expressions were ultimately only 'legitimate' in the context of a hospital birth with necessary obstetrical surveillance. This expresses, at the level of women's actual lived out choices, what Arney had described in relation to the transformation of obstetrics. That is, that '...birth should occur within a flexible system of obstetrical alternatives in which a woman's experience can take prominence against a background of obstetrical expertise and safety' (1982; p.220).

Natural childbirth as freedom from intervention

Some women defined natural childbirth in terms of pregnancy and birth being free from some types of (obstetric) intervention. However, women differed in their ideas of the type of intervention considered as contrary to natural childbirth. Many perceived natural childbirth as having something to do with a drugs free labour. For example, Bella knew that it would '*hurt like hell*', perceiving, however, such pain, as considered earlier, to be in some way 'worthy'. She still, therefore, wanted to give birth with no or little pain relief. Diane experienced pre-eclampsia in three pregnancies and needed hospitalisation for an average of three weeks with each episode. When considering natural childbirth she

believed there was a need to be flexible although for her childbirth in terms of freedom from chemical intervention, was preferable. Such women therefore did seem to embrace this fundamental aspect of the natural childbirth model. Others, however, although identifying this aspect, rejected it. Three women, who defined natural childbirth in terms of drugs free labour, rejected the idea on the basis of fearing the pain of birth. For example:

'Who the hell would want to put themselves through all the pain when they can have an epidural? I mean are they mad?'
(Carol)

Such accounts illustrate, therefore, the way in which some women did not contest the model's ideas on principle, but rather on the basis of self perceived cowardice in relation to labour pain. In doing so, however, they did not aspire to the essentialism within the natural childbirth model which suggests that females are capable of embracing and controlling childbirth pains. As well as this self defined fear of experiencing birth with no intervention, Carol also rejected the idea on the basis of assuming the legitimate place of the medical profession, again subverting the natural childbirth model's promotion of the dominance of childbearing women with regards to their ability to control the process.

'...really you have to put your trust in them and I think if you turn around and say to them I want to do it this way...I want natural birth control, I want to do breathing and aromatherapy, I think that's a load of rubbish. You should be guided by what the professionals say really.'

Other women understood natural childbirth in terms of freedom from other forms of intervention. Terri, for example, considered natural childbirth in terms of a hospital birth with everything (*'...gas, air and Tens machine'*) but a caesarean. Likewise, Ellen spoke of natural childbirth as meaning the absence of a caesarean but otherwise she was *'...quite happy to have all the drugs that they gave out'*, contrasting clearly with those who, as shown above, defined natural childbirth as a *'drugs free'* childbirth. Water births are a

birthing strategy also promoted by advocates of natural childbirth as part of their promotion of women giving birth in circumstances that suit their needs and wishes. Some women spoke of natural childbirth in terms of water births, both hospitalised and at home. An example of the former is seen in Linda's account. When asked whether she had any ideas about natural childbirth responded:

'I always thought I would quite like a water birth, I liked the idea of that in hospital'

Some women, although linking natural childbirth with water birth, considered it abnormal. Mags, who considered natural childbirth as akin to home birth, commented on water births '*...not being the normal ...*' way of delivering babies. What these responses suggest is that natural childbirth simply means different things to different women. How are we to make sense of this?

Research mentioned in Chapter Two showed how women's conceptualization of birth varies by factors such as social class (Nelson, 1983 and Zadoroznyj, 1999). That chapter also presented the arguments of those who criticise the natural childbirth model for its failure to reflect the lived experiences of women due to its inherent essentialism (Brooks and Lomax, 1999 and Annandale and Clarke, 1996). As indicated in Chapter Three and shown earlier in this chapter, my sample was largely middle class and the issue here was not the way in which women of different social classes assume different models of childbirth, but rather how the women understood and responded variously to one model of childbirth. What emerged is that some women, in expressing ideas about natural childbirth, drew upon concepts and technology ordinarily associated with the medical model. The first section of this chapter identified women's expectations and how they initially suggested a contestation to the medical model by being infused with assumptions of the

naturalness and normality of childbirth. It was, however, suggested that other cultural processes like the commodification of pregnancy and birth and the construction of the female body were also being expressed. The current section has explored women's ideas about natural childbirth and has shown that despite their general expectations, there was no unproblematic acceptance of this model. I will suggest that whilst their early images, and especially the marginalisation of any explicit notion of medical risk, reveal the impact of the natural childbirth model, the lived out actual choices of many of the women reflect some kind of pre-existing medicalised notion of pregnancy and birth. This is not a surprise given that, even amongst women totally dedicated to natural childbirth, medical definitions 'linger' (Monto, 1997). Closer analysis of the data, in particular looking carefully at the context of their whole experience, reveals the influence of more complex processes which suggest making sense of their expectations, ultimately, in terms of their accommodating a central notion of the medical model: that of risk. The next section attempts to demonstrate this.

Constructing Childbirth Expectations through Risk Engagement

In order to make sense of the complex and apparently sometimes contradictory ways in which women understood and responded to natural childbirth ideas, it is important to understand the broader context of their experience. Thus, I explored with women generally and in relation to pre-eclampsia, the type of information they had received during pregnancy, not only from health professionals, but also from their friends and family and how they had responded to these different sources of information. In exploring the conditions through which these early expectations might be understood, what emerged was that most women do engage with the possibility of risk. Defined as the probability of an adverse outcome (Becker and Nachtigall, 1994), the accounts show how women engaged

in a consideration of the possibility of risk to their own pregnancies. Whilst the word risk was rarely used, their early perceptions represent the result of a complex process through which this notion is sometimes manifest, often latent, but always present and engaged with. I show below the ways in which the considerations they engaged with were defined by recognition of possible adverse outcome.

Limited Information

Whilst it has been suggested throughout that the women all constructed their pregnancies as essentially normal, two of the women revealed how, previous to this conclusion they had in fact been initially concerned about a possible risk. As well as these women still arriving at a conclusion of normality after explicitly identifying a known risk, the latent presence of risk was identifiable throughout other aspects of their accounts and one factor influencing their awareness of such risk was the information made available.

Emma was one of the women who, although defining her pregnancy as normal, had begun it with concerns over a possible risk to its normality.

'I was delighted to find out I was pregnant but as I was thirty four and it was my first baby I was quite scared that something would go wrong'.

This self assessment of her own pregnancy as potentially risky was based upon her knowledge of certain known risks. Her fear concerned the possibility of Down syndrome, a risk made known to her. These knowable risks may have led some women to marginalise all other risks, like that of pre-eclampsia. For example, Emma's fear was proved unfounded and when this risk was proven to be insignificant, she did not consider other possible risks.

In her general reading about pregnancy she did not read about other complications. Emma had a son by emergency caesarean at twenty-six weeks, so seriously ill that he was quickly baptised. Her son did in fact survive. Her account demonstrates how women's early expressions were partly founded upon knowable risks. Irene too worried about Down syndrome because of her age. Like Emma, when this risk had been 'dealt with' by amniocentesis, she assumed the normality of her pregnancy and as seen earlier, conceptualised it in terms of 'ease', assuming that there would now be no problems. However, Irene became twenty-two weeks into her pregnancy. Her baby was delivered by emergency caesarean at twenty-eight weeks and spent nine weeks in neonatal care.

How far is it possible to suggest that the majority of women who expressed early expectations of childbirth in terms of its normality did so because of the nature of the information that they had received? In particular, to what extent was their level of knowledge about pre-eclampsia responsible for their consequent marginalisation or underestimation of it as a risk factor for them? Many women, including Emma and Irene, simply knew very little about pre-eclampsia. In part this was due to a lack of information presented about the condition, both written and verbal. Pregnancy was thus deemed a risk free phenomenon because particular threats to its normality were not made fully known, including the risk of pre-eclampsia. Twenty of the women explicitly mentioned the lack of information made available. This was experienced both within literature given and accessed about pregnancy and during routine antenatal appointments. Carol had never heard of it. She had read ... *'a bit about diabetes and a little bit about high blood pressure but nothing about pre-eclampsia'*. The reason for the various tests during her antenatal appointments was never explained to her. And she never asked. Carol just assumed *'...they were routine things that they do'*. Whilst Carol is the only woman who claimed to have never come across pre-eclampsia, either in written or verbal form, she is not alone in not having the purpose of routine testing and its association with detecting pre-eclampsia

explained. A further twelve, from the total sample of thirty women, also stated that they had received no information about the purpose of checks in relation to detecting possible risks to the pregnancy. Julie explained that she thought such test were merely routine.

'I really didn't know what they were looking for when they took your blood pressure. I just assumed it was a way of looking at your general health. Often the GP, when you go, will take your blood pressure if you have the flu and that's all I knew. So I just assumed it was another way of checking if your health was fine. I didn't realize what your actual blood pressure was to be honest. No, I just thought it was routine.'

As a result of pre-eclampsia, Julie had to spend six weeks in hospital as doctors tried to control her blood pressure. Her baby was delivered at thirty-one weeks by caesarean section.

Others, however, did receive some information about the checks, but the risk was felt to have either been underplayed or not directly linked to pre-eclampsia. An example of the former is expressed in Sandra's account. She was told at her antenatal appointment that they were looking for increased protein levels because that might indicate pre-eclampsia. She was told of possible symptoms like high blood pressure and swollen feet but she felt that the possible seriousness of the disease was down-played and this provides an explanation of her own response to the information, which was largely to marginalise it. This will be explored further in the next section. The apparent disjuncture between the information received and the reality of its consequences is explicitly revealed in Sandra's account.

'...they didn't go into all the symptoms of pre-eclampsia, you get high blood pressure and your feet swell up and you have to have bed rest. That was it. I didn't know you would end up having drips in you, everything falling apart on you, your liver packing up and things like that. I didn't realise how serious the illness was'

For three pregnancies, this marginalisation was of no significance. However, in her fourth she suffered severe pre-eclampsia at twenty-eight weeks. Her baby spent five months in neonatal care.

Irene too was given some information about why the checks were being done, for example, to make sure, she was told, that her blood pressure did not go too high. However, high blood pressure was not explicitly related to pre-eclampsia. Her major concern had been Down syndrome and as previously mentioned, for some women, identification of a known risk and then its marginalisation through particular testing procedures led to a sidelining of other risks, like that of pre-eclampsia. Belinda, who was diagnosed at twenty-eight weeks, was the only woman in the sample who recalled being told all about pre-eclampsia, including symptoms to look out for and being given a leaflet about the illness. She was only subsequently made aware, however, that the reason she received so much information was because she was deemed at risk after her first appointment because her blood pressure reading which was too high. After an emergency caesarean at thirty-four weeks she spent seven weeks in hospital.

In terms of written material, most women accessed not only that given at the 'booking-in' appointment in the form of the 'Bounty Pack', but also health books and pregnancy magazines. They were all keen to read about pregnancy. Again, however, the women reflected upon the way that such information had not been presented in a manner which led them to really understand and engage with the possibility of pre-eclampsia. For example, Julie recalled being given a folder by her doctor which just had '*...a couple of things about eating well*' and a big pregnancy book bought by her partner which had a '*little bit about pre-eclampsia*' but was otherwise focussed on general health. The same story is repeated among a further six of the women including Brenda.

'When I got the books from the health authority and I sort of saw the words, a few sentences that they put in mentioning it but that was all. I didn't realise the implications of it'

Fran, from a nursing background experienced pre-eclampsia in her first pregnancy at twenty-eight weeks. She *'...read up as much as (I) could on pregnancy'* but only found *'the odd paragraph'*. And for others, the information was 'there' but the naming of it as pre-eclampsia, absent. For example, Mary had pre-eclampsia twice leading to caesarean sections in both. In recalling the information that she had accessed about the disease, she stated:

'When I read through the pregnancy books there were only two or three lines about pre-eclampsia but it was not called that. It just said protein in the urine and swelling.'
(Mary)

Thus, not all risks were made known to the women in my research. When the risk of pre-eclampsia was made known, be it verbally through the exchange during antenatal appointments, or in written form within various texts, its presentation was one which led them to underestimate its seriousness and potential impact upon their pregnancy. However, further analysis of their accounts suggest that any conclusion linking level of information made available and recognition of the risk of pre-eclampsia is itself too simplistic. Women were aware of *certain* risks though in only two cases did this initially affect their early expectations of pregnancy and birth. There is no clear relationship between knowledge of health risks and changed behaviour since such knowledge is also mediated by other factors. This process has previously been revealed. For example, Becker and Nachtigall's (1994) research on couples going through infertility treatment showed how the women's biography and bodily knowledge affected how they constructed the risks involved. It could

be argued, therefore, that although the knowledge of certain risks, like that of pre-eclampsia, needs to be made known if women are to engage in them fully, information alone will not help us explain their subsequent response as expressed in their early expectations of pregnancy and birth. I have instead identified two processes which appeared to have influenced women's response to known risks in this sample: their marginalisation of relevant information and the influence of friends and family upon their construction of risk as it applied to their own pregnancy and birth.

Marginalising Information

The term marginalisation is used here to describe a process whereby some women chose to ignore or underplay the significance of information concerning serious pregnancy complications. This process was identified as one through which women's expectations of pregnancy were constructed and sustained. Seven women directly told of their ignoring or not really paying too much attention to information that they had had made accessible concerning serious problems on pregnancy. There were various reasons for this. Julie, who had noted how there was little information available in the literature given, later recalled how there was in fact a page dedicated to problematic pregnancies but that she had never read it. Likewise, on reflection she noted how there was a poster in the doctor's surgery about pre-eclampsia but she had never read that either. This is explained through her assumption that any risks were relevant to the early period in pregnancy. Given that she had had various tests and a scan, she assumed her pregnancy was risk free. Julie recognised some notion of possible risk in pregnancy but assumed that it would have been detected via medical technology early in pregnancy. She therefore distanced her pregnancy from the status of 'at risk' and this clearly had implications in terms of her response to subsequent information concerning possible problems.

'I just thought it would be normal, just getting bigger...I just thought you would go into hospital and you would have your baby and within a few days I would be at home...I felt sure my pregnancy had gone fine...I'd had all the tests, the double test, my blood test, at first stages of pregnancy and I'd had my scan and I thought that once I got to that stage, five, six months, and then you carry on getting bigger and then you have the baby...I never thought I needed to look at a page like that.'

Bella also assumed that by going to the doctor every week, any problematic symptoms would be picked up and responded to. This explains how some women arrived at a sense of their pregnancy as being normal and natural, not through a rejection of the role of medical surveillance, but through its incorporation.

As well as marginalising the available information on the assumption that it was not relevant to them, some women failed to understand the significance of the information about risks in relation to their own pregnancies because of the nature of its presentation. Some of the accounts suggest that women underestimated the seriousness of pre-eclampsia and were less likely to recognise its relevance to them if the information concerning it was only given brief mention.

'One of the ante natal classes I went to touched on various complications and pre-eclampsia came up and it was one of those topics that they gave ten minutes to and then move on to the next one...I didn't take much notice.'
(Bella)

Furthermore, some did not appreciate the information because of a narrow conception of its nature presented to them. Bella, for example, also recalled how she was led to think it was only a matter of high blood pressure and, not having such problems, assumed the risk not to be relevant. Again, such accounts show how women arrive at a notion of their pregnancy as 'normal', not by ignoring all medical ideas about risk, but rather by engaging

with those risks in some way. When forms of knowledge about such risks are either not presented or seemingly not fully presented, women locate themselves within a risk free category. I will show later how this then comes to impact upon their reaction to emerging symptoms, but also the emotional consequences of finding themselves experiencing a pregnancy crisis.

Other women did not read about pregnancy complications, even though the literature was made available to them, because of fear. Brenda suffered from pre-eclampsia in both of her pregnancies. Both babies had to be delivered by caesarean at twenty-eight weeks.

'I didn't know anything about pre-eclampsia at the time. It was two words that I'd heard of ...It was probably a bit naive on my part but it was my first baby. You don't read the chapters in the book on when things go wrong because you don't want to know. I must admit that any problem pages I didn't read...I didn't want to frighten myself'
(Brenda)

The ignoring or underestimation of the importance of information concerning risks like pre-eclampsia was also explained in terms of a lack of embodied experience of such risks which might then sensitise them to such possibilities. Diane considered that she had read '*...a reasonable amount*' of information during her first pregnancy but admitted that '*...unless its something that affects you, you don't actually pick up on it*'. She spoke now from the vantage point of someone who experienced pre-eclampsia in all three of her pregnancies and who could reflect on the way in which she went from someone who marginalised such risk to someone who would read up about it so that in her second and third pregnancy she would '*...know what she was talking about*'. A consideration of the impact of having experienced pre-eclampsia upon subsequent pregnancies will be further explored in Chapter Seven.

Referral Network

In assessing whether their own pregnancy had any associated risk, women would also consider others known to them, both members of their family and those more generally known or known of. Seven women made explicit reference to their own family's experiences of pregnancy. A lack of prior experience of serious problems in the family seems to be a basis upon which they assessed the relative importance or not of a known risk. For example, Sandra had no one in her family who had experienced such problems. The assumption was made therefore that this was a risk she could confidently assume would not be a defining feature of her pregnancy. Diane, too, spoke of having no problems with pregnancies in her family and this too was a basis upon which she assumed a relatively straightforward risk free pregnancy which she would '*sail through*'.

Other women reflected upon how they had assumed the normality of pregnancy through having no personal knowledge of anybody experiencing serious problems. For example, Belinda commented on how, not having '*heard any horror stories from anybody*', she assumed that she would experience a trouble-free pregnancy. Others made reference to friends' experiences. Irene for example '*...never really read up on...*' pre-eclampsia. The context for partly making sense of this was her lack of knowledge of anybody who had experienced pre-eclampsia. Whilst she had heard of friends who had high blood pressure, firstly, this had no serious consequences upon their pregnancies and, secondly, it was never connected to pre-eclampsia in her friends' accounts.

In summary, women's notions of the expected normality of their pregnancies were derived, not through a simple refusal to engage in the prospect of risk, but rather through a process whereby risk was attended to and yet discounted. The women who most explicitly

recalled ignoring or underestimating the significance of presented information on pre-eclampsia and other serious complications did so not on the basis of a conception of natural pregnancy premised upon a firm negation of medical concepts of risk. Rather, the marginalisation of the risk of pre-eclampsia was the result of engaging with the possibility of something going wrong. For some, this was carried out using the available knowledge and their embodied experiences. For others, it was premised upon a belief in the ability of medicine to detect risk. For some, however, risk was something simply too scary to engage in. These considerations of risk are affected by the information available but that information is itself interacted with in different ways as suggested above. These women had, I suggest, at some level and at some point, embraced some medicalised concepts of risk. This fact and, as earlier mentioned, their lived out pregnancy and birth choices, imply that these early images expectations of pregnancy as expressing its normality and naturalness are not unproblematically bound up with natural childbirth notions.

Developing Symptoms, Sustaining Normality

This chapter has so far considered the early perceptions of pregnancy held by women in my research and the processes through which their emergence might be understood. These processes constructed a context, not only within which women would perceive pregnancy, but through which they would make sense of developing symptoms of pre-eclampsia. This final section begins the process of exploring the lived experience of pre-eclampsia. The purpose of this part of the chapter is to show how, having considered risk in the ways previously described, they would often *redefine* symptoms in terms of the 'normal' phases and problems of any 'normal' and 'good' pregnancy. Some would underestimate the seriousness of symptoms by redefining them in terms of a 'normal' but 'bad' pregnancy. Symptoms normalised or underestimated in this way included severe swelling of hands

and feet, dizziness, bad pain under the ribs, headaches, a sense of 'feeling out of it', and breathlessness. Having deduced that their pregnancy was free from serious risk, it is not surprising that particular symptoms would be considered as not worthy of concern. However, the accounts show how this normalisation was not only the product of earlier considerations of possible problems, but was sustained and reproduced through other processes which are identified below. The section begins, however, with demonstrating this normalisation of developing symptoms as it was made evident in women's accounts.

The symptoms of pre-eclampsia are often exaggerations of the normal changes of pregnancy. Swelling, extra strain on the lungs and bouts of indigestion are not uncommon. These women knew of these common problematic but essentially normal and merely bothersome physical changes and, therefore, it is perhaps unsurprising that they initially considered their symptoms as representing such changes. Eight women explicitly related the ways in which they did this. Epigastric pain, a severe right sided pain under the ribs associated with liver problems, was thought to be indigestion. Swellings became considered as common expected consequences of being pregnant.

The following two examples illustrate this. Julie experienced dizzy spells and visual problems as well as headaches and a general feeling of being unwell. She '*...just assumed that... (the symptoms)...were just another part of your body changing and getting further pregnant*'. Brenda started to feel ill eighteen weeks into her pregnancy. She had oedema and pain on her right side, headaches and tiredness. She explained that all these symptoms of developing pre-eclampsia she had played down.

'To be honest I thought the swelling...people get swollen ankles when they get pregnant...(T)he epigastric pain was...I remember being quite pleased about it because I read in my book that you might get some pain because your ribs move a bit because your uterus is pushing up. I remember that 'cos I was pleased with the pain 'cos it must have meant that I was getting bigger. Head-

aches I just put to being tired. I just explained it away as being a normal part of the pregnancy'

Normalising problematic symptoms did not only take the form of seeing them in terms of the normal phases of pregnancy. It also took the form of defining them as aspects of a normal but 'bad' pregnancy. Brenda's account reveals this. When she was hospitalised she realised that the symptoms were not normal in the sense of being nothing to be concerned with. Until this point they remained defined by her as normal aspects of a 'bad' pregnancy.

'I just thought I was having a bad pregnancy. You know some people do don't they? I just thought I was having an extreme case of it'

In such accounts, a bad pregnancy is not defined as abnormal; it is rather seen as a normal pregnancy which is not 'good'. Clearly then, the transition into patienthood in pregnancy is a complex process, dependent not simply upon a given set of physical indicators, but rather on an interpretive process influenced by the factors isolated previously in this chapter as constructing normality.

I have argued in this chapter that women do engage with a central concept of the medical model, that of risk, as part of the process through which they construct their expectations of pregnancy and birth. One of the questions that emerge from my consideration so far is how it is possible that, in the context of developing symptoms and a process whereby risk was manifestly or latently part of the construction of their expectations, the women did in fact sustain this normalisation. The construction of the normality of their pregnancy was evident, but why, given the premise of risk, did risk not emerge easily again when symptoms of abnormality developed? I suggest that the answer is that other processes operated to sustain their perception of normality. Three are visible through women's accounts.

Most women who explicitly defined pre-eclampsia symptoms as normal were in their first pregnancy. Some stated how they felt this to be the reason for their apparent ignorance concerning the nature of the symptoms. They were simply unaware of the discomfort to expect and were, therefore, more likely to normalise it. The following example reveals this. Joanne felt that her status as a first time pregnant woman made it difficult for her to know what was and what was not normal. This coupled with the feeling of '*being petty*'; again emerging partly in consequence of her lack of experience, led her to not seek advice when problems initially emerged.

'...it's like you think you're being petty...people say that 'oh yeah you do get aches and pains... But then sometimes you think well is that pain supposed to be there or what? ...but then the first time round you don't know.'

Likewise, Suzanne did not feel well but '*...being [my] first pregnancy [I] didn't know any different...*'. She felt everyone experienced what she was going through and it was simply a product of the later stages of pregnancy.

Women, who had experienced pre-eclampsia more than once, however, were in a different position. They recognised the symptoms and quickly defined them as problematic and in need of medical supervision and intervention. This was even the case with clinical symptoms that produced no overt physical changes. Linda demonstrated this. In her first pregnancy, she did not feel unwell and was therefore unhappy to stay in hospital after high blood pressure and proteinuria had been detected. In her second pregnancy she would again feel well despite experiencing pre-eclampsia. However:

'The second time round I knew about it and I was happy to do whatever I was told to do...'

Chapter Seven will consider further the impact of experiencing pre-eclampsia upon women's responses to medical surveillance and intervention in subsequent pregnancies.

A second way in which some women accounted for the way they sustained a sense of the normality of their pregnancy, despite developing symptoms, related to their physical experience of the developing illness. Nine of the women spoke or wrote of 'feeling fine' at some point during the physical changes associated with pre-eclampsia. This led some to normalise symptoms as shown with the following example. Joanne began to experience severe swelling but was shocked when she was told she would have to be hospitalized.

'...it didn't seem to get any better. But I felt fine in myself. I felt as though there was nothing wrong with me. I'd got over my cold and I'd had two weeks off work and I thought [great]. I went back to the doctors to find out when I could go back to work and that was it. I was sent straight to the hospital.'

Thirdly, women's experience of the bodily changes associated with pre-eclampsia took them to their doctor, midwife and to friends and family. Sometimes these directly normalised the symptoms.

'The second week I just started swelling up. The midwife told me the baby was going to be bigger than the rest of my children and I thought because I was so big that was the case but it wasn't. I mean he only came out at one pound six ounces.'

(Pat)

Jane began to experience symptoms at twenty-seven weeks.

'The first symptoms of pre-eclampsia I experienced was swollen ankles a week prior to being admitted to hospital. Over the next three days I developed a pain in my gullet which friends assured me was indigestion. I tried to sleep propped

up and developed a stiff neck as a result. I then visited my GP who prescribed indigestion and rubbing ointment but did not check my urine sample.'
(Jane)

After experiencing vomiting and headaches, she was hospitalised, had an emergency delivery and spent time in a high dependency unit.

A central question I raised at the beginning of this section was how normality was sustained even with emerging symptoms against a backdrop of women having actually engaged at some level with the prospect of pregnancy complications. I have suggested that these three factors, previous childbirth experiences, physical and subjective feelings of being 'fine' and the existence of friends and others, including health professionals, who would normalise women's emerging symptoms of pre-eclampsia, help explain why this is so.

Summary

This chapter has revealed the early images of pregnancy of the women in the sample and I have attempted to understand these in relation to both the natural childbirth and medical model. Early expectations were found to be those which seemed to express notions of the naturalness and normality of pregnancy. I had initially, therefore, considered that this was expressing natural childbirth notions. Insofar as this was the case, it might have been possible to claim that my findings illustrated what Graham and Oakley (1981) had previously referred to as 'competing' models of childbirth. A closer exploration, however, suggested something more complex. Not only do the different expressions suggest a partial accommodation to natural childbirth notions but, in tracing the origins of these early images, what becomes clear is that women had engaged with medically defined risk at

some level. Risk as a medical concept was not, however, considered unproblematically. It would seem rather that they have 'heard' of certain ideas about possible childbirth problems which are then mediated through the influence of peers, information accessed and previous experiences. However, they do indeed engage in a process whereby risk is engaged with. The conclusion of this is a set of pregnancy expectations which are not truly 'competing', as initially considered. Rather, they are partially premised upon an assumption of the very model they are meant to 'compete' with, that of risk. When symptoms emerge, this assumption of normality is reproduced through the three ways described previously.

When the research began, 'risk' was evident to me only with respect to the way in which obstetrics justified routine intervention and surveillance on the basis of its possible existence. I had not expected that it would emerge as a central theme from my primary data. It did not therefore form the basis of my literature review. My consideration of the impact of this emerging theme, in relation to some of the key ideas in sociological considerations of risk, will be explored in Chapter Eight. It will be there also that I will address the following question: Given this emerging issue, what is its significance to my critique of existing feminist contributions to childbirth? We now, however, turn from the situation whereby women developed symptoms which they normalised, to one within which their abnormality would be defined for them and dealt with medically.

Chapter Five

Experiencing Abnormality

This chapter is concerned with women's physical and subjective experiences of pre-eclampsia from the time when serious medical concern was raised and they were thus hospitalised. It has five basic concerns. Firstly, the chapter begins by considering the way in which the women in the sample responded to developing medical concern with their pregnancies. Just as the transition from assumed normality to confirmed abnormality did not simply occur with the development of problematic symptoms, this chapter will show how the transition was not solely dependent upon raised medical concern. I suggest here how women's continual normalisation of symptoms and their response to pain illustrate some essential issues which can be interpreted in terms of insights from the sociology of embodiment. The conditions through which women would locate themselves within a category of 'abnormality' are identified also. This chapter will, secondly, explore women's emotional responses to pre-eclampsia and physical experiences of the illness. Fear dominates their accounts and I identify some of the causes of this response. Other subjective experiences, including a feeling of guilt and the development of a negative self image as the illness caused changes to their body, are also explored. In the previous chapter I suggested that women, though their early expectations, seemed partly to express concepts central to the natural childbirth model. However, closer analysis revealed that they arrived at such conclusions through a process where they engaged in risk. In the current chapter, I further suggest the significance of the risk concept as a way of understanding some of the women's subjective responses, in particular that of guilt.

Chapter Two considered feminist criticisms of the failure of maternity care defined by the medical model to fully integrate in an empowering way the subjective dimensions of childbearing women. A third concern of this chapter is to demonstrate that such concerns are also relevant to women experiencing a serious complication of pregnancy and yet it is in such a context where their subjective needs can most easily be marginalised. The third section of this chapter will explore women's experiences of the medical concern received and will demonstrate that alongside their physical care, they required more recognition of their subjective needs. Some of these needs were also visible in some women's experiences of dealing with their babies in neonatal care units. Whilst the experience of dealing with a baby in neonatal care is not peculiar to women with pre-eclampsia, it nonetheless formed a part of their accounts concerning their experience of the illness. A fourth intention of this chapter is, therefore, to recount and explore women's experiences of dealing with their babies in neonatal care units. When women spoke or wrote of their experience of pre-eclampsia they often spoke or wrote about the family and or friends who were part of their social and kinship networks and linked to the women's experience. The final concern of this present chapter is to reveal how women, even in the context of necessary intervention, conceptualised and came to account for their experience in terms wider than simply that of the 'isolated patient'.

The Subjective Transition into Abnormality

Chapter Four showed how 'feeling fine' was one of the conditions through which it was possible to make sense of the way in which women normalised developing symptoms. Even upon hospitalisation, some women remained unaware of the seriousness of their condition because of a continued sense of 'feeling fine'. An embodied sense of feeling well, despite having serious pre-eclampsia, can make sense given the often 'hidden' nature

of the illness. High blood pressure and proteinuria can remain non symptomatic, requiring medical techniques to identify their existence. Two examples show this. On the day that Cerri would enter hospital, have her child and be in intensive care, she recalled '*...[I] didn't feel ill and [I] didn't feel sick. I just felt pregnant*'. This invisibility of pre-eclampsia was something reflected upon by Linda as the worse aspect of it.

'I didn't physically have any real symptoms. I was not feeling unwell myself or anything. It was only really that my blood pressure was quite high on a routine check and then when I was taken to hospital...I was like what is going on here you know I felt physically fine. I was sitting up in bed. I couldn't understand it...The most frightening part of pre-eclampsia is that...this is going on inside of you and you have no idea, you can't feel anything, you don't know that it's happening.'

(Linda)

The conclusion that they were free from serious risk was even sustained, with some of the women, in the context of being told that, not only were they ill, but that it could get worse. Lorraine's account illustrates this.

'Well they said to me these are the symptoms of pre-eclampsia so we want you to stay...[she asked]can I go home because obviously I was bored and I lived probably three to four minutes away from the hospital...that's when they sat down with me and said that it could all go wild all in a couple of minutes and then you would need to have the baby here and now...but even then I didn't think it could happen to me...I was feeling fine really apart from a slight headache.'

(Lorraine)

For others, even knowledge of the problems that were invisible to them did not initially change their perception of their situation. They instead gave prominence to their own embodied experience. Joanne, for example, '*felt fine*' and was not therefore concerned with her diagnosed high blood pressure:

'...well it's just a medical thing...because you can't see your blood pressure,

you don't think about it.'

The responses of the women cannot, however, be divorced from the context within which they came to conceptualise their own pregnancies. In the previous chapter I showed how factors such as limited information and marginalisation of information concerning certain types of pregnancy problems like pre-eclampsia made sense of their conclusion of not 'being at risk' and their subsequent tendency to normalise developing symptoms. Given this context, the apparent failure of some to fully understand the seriousness of their illness despite concerns shown by the medical profession by some of the women makes sense when coupled with a physical sense of being well.

Whilst some women remained unaware of the seriousness of their condition even when advised that they were having problems, other women's assumptions of normality were disrupted more quickly through the increasing 'visibility' of the illness. This visibility related, firstly, to the emerging sense of feeling unwell.

'I wasn't so much frightened of it until I got poorly and I had a lot of epigastric pain and that had been explained that that was the placenta not functioning properly and that is where things can get quite bad for the baby as well ...and that's when I started to get frightened...up until then I was frustrated [and] every day I would beg to go home saying that I felt better...'
(Julie)

Secondly, for other women, despite 'feeling fine' medical concern brought as increasing realisation of their predicament.

'My thoughts on being told were numb because I felt so well even until a week before my daughter was born. I felt really scared because I felt really well but the midwives were very concerned keeping an eye on me and at one time I had three consultants looking after me.'
(Mary)

For some women, this increasing sense of feeling unwell was coupled, secondly, with an overt medical concern for them before they began to understand how serious their situation was.

'I started getting pains in my chest...I was being sick...I had started to swell up...[the midwife] sent me to the hospital but I thought that they were just going to check me out and send me home...I just thought I wasn't well, I was under the weather. It all came as a bit of a shock that I was going to have to stay in.'

(Sandra)

The increasing visibility of pre-eclampsia emerged, therefore, with developing symptoms causing a sense of 'feeling unwell' alongside growing medical concern. This disrupted the expectations of those who initially remained unaware of the seriousness of their condition. Furthermore, when some ceased to 'feel fine' with the onset of further, less hidden complications, they began to fear. This change in their embodied experience led to their redefining their pregnancies and births as problematic. This transition into abnormality was complete and they would begin to subjectively encounter a transformed pregnancy, the dimensions of which are now explored.

The increasing visibility of women's illness and their concern and worry were simultaneous. When recalling their experience of pre-eclampsia, what dominated was the subjective experience of fear. This fear was expressed in different ways including a feeling of dread, alarm, being scared and anxious. For some women medical interventions would induce fear.

'Within fourteen minutes of having giving birth suddenly I had an eclamptic fit...I was unconscious ...and taken to intensive care where I was out for three days, then I came round again...I was quite scared cos I was hooked up in various places on my body.'

(Bella)

Such fear was heightened when the reasons for particular types of intervention were not fully explained. Sandra's response to medical intervention illustrates this.

I just felt really frightened to start with, they were just rushing around me and doing all these things to me and I didn't really understand what they were doing to me... ' (Sandra)

After being hospitalised, Julie was taken to be scanned. She had not been told that the actual results would only be shared with her by her consultant. That was the procedure. When the radiologist simply told her that she would have to wait and see her consultant she:

'...absolutely freaked and by the time I got back to the ward I was crying and was practically throwing a tantrum because I didn't understand why she frightened me and wouldn't tell me any further'.

Julie's and Sandra's accounts show how a lack of understanding and information regarding what was happening exacerbated fear. This is not surprising given that not understanding what is happening in such situations can reduce feelings of being in control and research has shown how feeling in control is related to positive psychological outcomes (Green and Baston, 2003).

Women also became fearful when the impact of pre-eclampsia upon their babies and their own lives became known.

'At that stage I became very frightened. In my mind I did not yet have a baby inside me...it was a funny foetus that could not possibly survive. Although I was

aware that it had become viable at around twenty four weeks I still felt it was too early'
(Jane)

Sharon was admitted to hospital with pre-eclampsia at twenty-seven weeks. She had a caesarean at thirty-six weeks and had to remain on oxygen for twenty-four hours. Her baby spent nine weeks in neonatal care.

'I don't think I've ever been so scared. I thought I was going to die.'
(Sharon)

The women had begun their pregnancies with a conceptualisation of its normality. Illness challenged that assumption. The recognition of the illness and its seriousness was for many a late one. Many were unprepared. Most of the women in the study knew very little about pre-eclampsia, its symptoms and potential consequences and how it is managed medically. An apparent lack of information experienced by some women during hospitalisation compounded the problem. This left them in a situation where they experienced a lack of control and therefore felt fearful. Whilst fear dominated the women's responses, other emotions were also described. Distress was common, as was a sense of loneliness and guilt.

'On Saturday when my husband and mother came to visit me in the afternoon I even said that I thought I would be home soon. Later that evening the doctor came to me and said that he thought the baby would have to be delivered quite soon. That was the first time I cried. I felt so lonely.'
(Emma)

Many of the women remained ill for days and sometimes weeks after their babies had been born. Some spoke or wrote at length about the way that some of the procedures around their treatment produced emotional distress in relation to their role as mother. Nadine, for example, had to spend time in the intensive care unit with liver and renal

failure following severe pre-eclampsia diagnosed at thirty-four weeks. She was separated from her baby for a week. When reunited with him in hospital medical interventions caused her emotional distress.

'I was beginning to feel very despondent and felt so inadequate...the intravenous infusion sites in my arms and access lines for dialysis making it difficult for me to care for Carl.'

Julie also found it difficult to look after a sick baby in hospital whilst she herself was ill and receiving care. Her own medical care led her to feel useless in terms of her ability to care for her baby. She explained:

'...I didn't want to be responsible for a child while I was on morphine because I just felt so funny on it...I couldn't get up because I had such trouble walking because the pain from this clot that had formed was just absolute agony and I found it quite difficult being in the hospital and feeling quite useless'

A feeling of guilt was common amongst the sample of women. This feeling can be seen as related to the way in which women had previously engaged with risk, as considered in Chapter Four. Cerri found herself ill. She asked herself *'...what have I done wrong...you know I never drank, I didn't smoke...perhaps I shouldn't have worked five days'*. Cerri's words indicate that her self assessment of risk had marginalised it on the basis of 'risk reduction' activities. Insights from the sociology of risk help make some sense of the ways in which women engaged with risk. In a summary of the sociology of risk literature, Zinn (2004) argues that research suggests that people's conceptualisations of risk are constructed through referring to different and sometimes contradictory forms of knowledge, with expert knowledge being but one. Chapter Four did indeed show this to be the case insofar as peers and kin impacted upon their risk ideas. However, others have also suggested that medical constructions of risk may nevertheless dominate lay ones (Becker

and Nachtigall, 1994). I suggest that it is in women's guilt response to pre-eclampsia that we can detect this dominance. Medical conceptions of risk are premised upon an individualising of risk with associated notions of risk reduction life styles. Cerri, for example, had engaged in these notions by trying to control the risk known through not drinking and smoking and yet then reflects on the possibility of working too hard as a risky activity. However, the focus upon self control is also a focus within the language of the natural childbirth movement (Layne, 2003). That women can control birth outcomes by learning to manage their pregnancy and childbirth experience further encourages the belief in the blameworthiness of those whose pregnancies do not end so happily. I suggest therefore that the feelings of those like Cerri make sense in the context of the various conceptions of birth and associated risk knowledge available and accessed by her.

The experiences of two other women illustrate this argument further. Mary spoke of a sense of 'punishment' in relation to the medical treatment given. When her blood pressure went up she was made to lie on her side for an hour. This made her feel like a '*naughty child*' who was being '*punished*'. High blood pressure is linked to 'risky behaviour' like being overweight, not exercising and so on. It is something that one can, with self effort, 'take control off'. At the time of her illness and early delivery, Emma recounted her feeling guilty about not carrying to full term. '*...[A]t the time I thought it was punishment for something*'. Emma had entered pregnancy with a sense of risk, the risk associated with having a child with Down syndrome. Having controlled that risk through a test which proved negative, Emma was then confronted with a disease that she had not accounted for; perhaps explaining the feeling of guilt.

As well as these subjective responses, some women told of how they experienced negative feelings because of the impact of pre-eclampsia upon their body image. The oedema that often characterises pre-eclampsia can severely distort a woman's body. For

example, Emma had swelling that included her mouth and face. She recalled how she '*...was so ashamed of how (she) looked*'. Julie describes how her face and neck '*...just blew up like a balloon*' and Irene says she looked like '*...the elephant woman*'. Suzanne described her emotional response to the bodily changes caused by oedema:

'I was huge, I felt horrible, ugly and overweight'

Such bodily distortions contrasted with those physical changes considered by women as part of normal pregnancy. I argued in Chapter Four that women's early expectations of pregnancy included ideals of pregnant physicality which reflected wider constructions of female embodiment but more fundamentally also reflected the physicality of normal pregnancy. Some of the women in my research never reached that stage, due to early deliveries, where their 'bumps' would show and they would 'glow'. As shown above, others would experience a distortion of the expected bodily changes, impacting upon their self image. Responses like being ashamed and feeling ugly testify to the power of such expectations.

Physical Pain

The transition into abnormality, brought about by the increasing visibility of pre-eclampsia, presented women with a range of subjective challenges, from fear through to guilt and the dilemmas of emotionally dealing with a body transformed through the illness. Pre-eclampsia also, however, presented many of the women with physical pain. Women experiencing pre-eclampsia suffer various types of physical pain emerging from the disease itself especially when it begins to enter into an advanced form including head pains and pain from a swollen liver (Action on Pre-eclampsia, 2006). The women in my research

recalled many aspects of the physical pain they experienced. For example, Carol recalled 'crying in agony' in the bed as pre-eclampsia caused her liver to swell. Bella remembered her 'excruciating headaches' where her head was '...hurting so much, the pressure I thought my eyes were going to pop out'. Sandra's chest pains felt like she '... was being stabbed all the time'.

Pain emerged for the women, not just from the disease itself but from the nature of the treatment they received. Jo spoke of her 'agony' on having her catheter removed. Anne was twenty-seven weeks pregnant when diagnosed. She described the pain encountered upon preparation for an emergency caesarean.

'I remember them giving me the magnesium sulphate...They say it gives you this warm feeling, it didn't. It felt like I was in a furnace and I couldn't breathe, I felt like I was wetting myself and I felt like I had no control, it felt like I was drowning in heat.'
(Anne)

Anne experienced an eclamptic seizure and spent three weeks in hospital, with some time on full life support. Her baby spent eight months in hospital, needing oxygen for two years.

Chapter Four showed how for some women, their early ideas about pregnancy and childbirth embraced a notion of pain as something that was natural and to be embraced and managed. For others, it was something that was normal but to be avoided. For many, their experience of pre-eclampsia presented them with pain that was unavoidable, impossible to embrace and controlled only with medical intervention. I suggest that this illustrates some of the critical points raised by those who criticise natural childbirth's inability to embrace women's varied experiences, reviewed in Chapter Two. The language and understanding of the pain of pre-eclampsia was available to such women only within the confines of the

medical model. The consequences of this will shortly be seen in this chapter where I show that though their physical needs were met, many felt their wider needs were neglected.

The data also illustrates ideas that have emerged from the sociology of embodiment. Embodiment refers to our experience of living in and through our physical bodies. Bodies are of sociological interest insofar as they are 'acted upon' by society (Turner, 1984) and the experience of them in pain, for example, is mediated by the social (Bendelow and Williams, 1995; Williams and Bendelow, 1998 and Bendelow, 1993). The previous chapter thus showed how, in perceptions of pregnancy and birth, pain can be differently conceptualised. Furthermore, some pain, even that indicative of 'something wrong', can be normalised. The current chapter has also shown the degree to which the affective and sensory are intertwined insofar as fear will sometimes be engendered only by some types of pain. Physical changes will also cause changes in self concept at the level of 'attractiveness', that itself reflecting culturally constructed conceptions of pregnant physicality.

The transition into and experience of a pregnancy which deviates from normality cannot be divorced from the medical care context within which women become located. Their experience of abnormality is, therefore, an experience also of such care. The analysis of the primary data reveals the nature of women's experiences with this care.

Experiences of Medical Care: Physical Care and Subjective Need

Some of the women spoke or wrote positively about the physical care they received. They were thankful to have survived pre-eclampsia and explained it in terms of medical technology and expertise. However, in telling of their care most of these women also

highlighted what they considered were limitations in their treatment. Their responses clearly suggest that they define their health care needs in a holistic way, incorporating care and sensitivity for the woman's subjective self as well as curtailment of physical morbidity and mortality. Other women isolated aspects of social and emotional care received by the medical profession and defined them in a positive way. Subjective care was important. Of the eighteen women who spoke or wrote negatively in some way about their care, thirteen isolated the failure to deal with needs other than that of ensuring survival and physical morbidity. Nine women told of their care in a negative way only. However, many of these were keen to understand the perceived limitations in their care health by making reference to things like the 'busyness' of the staff and the lack of resources. The picture that emerges then from the research is not one of a simple distinction between women who had negative experiences of health care and those who had positive experiences. Rather, it is one of some women telling of the positive aspects to their care, whilst also isolating problems, and others of their negative experiences whilst also, in some cases, attempting to account for the apparent care limitations. The fundamental picture, however, is one of women themselves feeling that their health care needs were much more holistic than that which many of them actually experienced as being met.

Eight women explicitly told of their happiness regarding the physical health care they received during pre-eclampsia. Some particularly isolated the intensive nature of it. Pat, for example, commended the fact that her care was literally twenty-four hour care. Lorraine expressed appreciative surprise at the sheer number of professionals looking after her and Amanda was 'impressed' with the '*...large intensive care chart being completed about [me]*'. Others were aware of the fact that doctors and midwives responded with an air of emergency and appreciated this.

'The care I received was really really good from my experience. They were all

arms on and it was a matter of get this baby out.'
(Cerri)

The relationship between being informed and experiencing health care more positively is illustrated in Diane's experience of pre-eclampsia. She had to deliver her baby at thirty-four weeks. She spoke of her midwife being 'very good' because she talked her through the options. She reflected on how:

'...the fear departed because you actually felt in control of what was going on. I think it is the lack of control that is the scary bit, not knowing exactly what is happening.'

From the eight women who isolated the positive aspects of their physical care, however, five went on to write or speak of the limitations as they perceived them. Amanda was thirty weeks pregnant when diagnosed with pre-eclampsia. Her baby had to spend ten weeks in neonatal care. Whilst Amanda, for example, was impressed by the technological efficiency of those who looked after her, her account shows how this efficiency occurred alongside a failure to recognise her subjective needs.

'The care during my first pregnancy was good. Pre-eclampsia was diagnosed and I didn't develop eclampsia but it was very impersonal and very uninformative and I never seemed to know the state of MY health.'

'...the actual day to day care was fine, but what I needed more than anything was someone to give me some information. Explain to me or give me a leaflet...'
(Linda)

Some women described insensitive practices which reflected a failure to consider them as more than isolated childbearing patients.

'I saw this guy who I think was a consultant who didn't introduce himself, didn't actually speak to me at all. I was treated like a person in a bed and it was do this and do this and he walked out again...I felt stunned. (Fran)'

Sandra, for example, described how in front of her husband of twelve years she was asked whether she had changed her partners. A change of partner can have some causality on developing pre-eclampsia.

Another illustration of women's appreciation of the physical care but dismay at the failure to recognise wider needs as important is seen in Jane's account. She spoke of the 'exceptional care' received whilst in a high dependency unit as a result of pre-eclampsia after her baby was born at twenty-four weeks gestation. Having a consultant supervise her care and being monitored by a midwife twenty-four hours of the day were aspects that she commended. However, Jane summarised that *'[O]n the whole I do not feel I received care appropriate to my needs'*. The 'need' that she identified was the need to be kept separate from other mothers on the post natal ward who were well and had their babies with them. For Jane, this was a fundamental part of her care.

Women saw their care in wider terms than physical survival. They too, like women who experience unproblematic pregnancies and birth, had subjective needs. Further support for this can be seen in other women's accounts where 'good care' becomes equated with that which goes beyond meeting purely their physical needs. Women isolated good professionals as those who were informative and supportive.

'They were very good actually and I cannot fault the staff....I saw my consultant not all the time but he did come down regularly to see me, but his registrar, she was wonderful. She came every day and when I was getting quite depressed....she would pop in after her shift. The midwives, if they were not too

busy, would actually sit down and talk about it.'
(Julie)

Taking the time to talk to women and informing them about their illness and the medical procedures being carried out were isolated as positive aspects. 'Calming' and 'understanding' were also adjectives used to denote good care experiences. Being supportive was sometimes shown in a practical way. For example, Mags described herself as being traumatised by pre-eclampsia and the need to have an emergency caesarean. She reflected upon the support and understanding shown by one midwife and the reason why such support may be unusual.

'She actually let me phone [husband] up and she got a roll away bed and let him stay with me for the night. Now there are not many midwives that would have done that but she was very sweet and I guess most of them because they had seen it done ex number of times, they are perhaps a bit insensitive to it.'

Eighteen women in total identified limitations in the care received. They were critical of the lack of information given about their illness, the lack of general support and the sometimes insensitive nature of care provision. These women found themselves situated within a context of necessary and often high levels of medical intervention. Holistic aspects of maternity care that are promoted as a challenge to its medicalisation are and often were for many of the women easily marginalised in serious problems of pregnancy. This part of the chapter has revealed that women themselves consider them significant even in a context of necessary, sometimes life saving intervention. The problem with the informational, social and emotional needs of pregnant women being marginalised is, as shown in Chapter Two, a central concern to the feminist critique. However, as argued there, such concern is focused upon women, whose pregnancies are only problematised by unnecessary intervention, largely ignoring the needs of women who require high levels of intervention. The challenge takes the form of promoting a model of maternity care within

which women's subjectivity is central. In relegating those women with problematic pregnancies, however, to a side issue, this challenge to obstetrics is made available only to those whose pregnancies do not demand such intervention. This is despite the fact that women whose pregnancies do demand intervention may, like those in my research, voice the need for their subjectivity to become more centralised. The social aspects of women's experiences of a physically challenging pregnancy are also revealed in the further ways in which their experiences are beyond that defined only by their own physicality.

Women's accounts of pre-eclampsia were also, for many, a story of dealing with babies in neonatal care units. Pre-eclampsia was also an experience lived through by other significant others. In recounting their memories of pre-eclampsia, women spoke or wrote of their experiences of dealing with their hospitalised babies and the experiences of other significant others, the roles they played and their own dealings with the situation. This chapter now deals with these in turn.

Experiencing Neonatal Care

In exploring the experience of pre-eclampsia, women's accounts told not only of their physical and subjective experiences in relation to themselves, but also their experiences of dealing with babies in neonatal care. All but two of the women in the study had their babies transferred to a Neonatal Unit. There are around two hundred and fifty-five neonatal units in the UK. They offer three levels of care for the newborn. Special Care involves being tube fed, receiving phototherapy and breathing monitoring; High Dependency Care deals with the problems faced by babies under 1,000gms including nasal continuous airway pressure. The third level is Intensive Care for babies requiring respiratory support (BLISS, 2005). With pre-eclampsia as one of the major causes of premature births, it is

not surprising that many of the women had such an experience. Seventeen women spoke or wrote explicitly about their experiences of being separated from their child. The length of time that their babies spent in neonatal care ranged from one day to over eight months. Five of the women would not see their babies for a number of days as they themselves were considered too ill. Many of the women reflected upon the distress of this. For some, such distress emerged from the unfulfilled expectations of what the birth and their baby would be like and the assumed 'happiness' (considered in the previous chapter) which would characterise the experience.

'Well I didn't feel well. I just felt awful. I sort of looked at him. That's it really because I had always imagined this big fat blonde bouncing baby and he wasn't. He had loads of dark hair. He weighed nothing and he had wires and things attached to him... They wheeled this cot down with me and all that was in it was a few cards and a bunch of flowers and people [were] saying, well where is your baby and I thought this is horrible.'
(Carol)

The level of emotional trauma that some women experienced was vividly illustrated by Mags who was a policewoman. She described how she has seen some horrible things:

'...I have picked up pieces of brain, I have seen to bodies, countless of dead bodies. This thing (pre-eclampsia and an ill baby) just knocks you, completely, absolutely, absolutely...'

Another emotional response described was that of feeling 'distant' and alienated from their babies. This feeling partly emerged from the initial separation at birth of mother and child and in some cases fear of bonding with a seriously ill baby.

'I did not have that initial motherly bond... I was quite upset... because you are supposed to be a mother now and you are supposed to really love this baby but I didn't have that feeling. But I possibly didn't have it in case something happened to her; it was going to hurt more...'
(Fran)

'I had completely forgotten that I was the mother to be quite honest. I sort of had the feeling that I had had this baby but it was not mine, I went through giving birth, that's all I had done.'
(Irene)

However, these feelings seemed to have been reproduced through the medical procedures necessary for the care of the baby.

'It wasn't a natural thing, it was a medical thing cos when you lifted him out of the cot you had to take the alarm off and the drip off his nose because he was tube fed...so it was medical, it wasn't like sitting and giving someone a bottle...it was quite sterile.'
(Cerri)

The procedures surrounding the care of the baby, as reflected upon by some of the women also developed such a sense of alienation. Such procedures objectified the baby and spoke of the baby belonging primarily to the hospital.

'...the nurses sometimes would be watching over your shoulder, watching to see what you were doing. We had to ask permission to take her out of the incubator and then you would be cuddling her for a little while and you would be told I think you should be putting her back now.'
(Linda)

Cerri felt just like a 'visitor' in having to 'knock on the door as if I shouldn't be there'. Sandra described feeling 'in the way' of those caring for her baby. The results were revealed in the accounts. Cerri felt as though she '... didn't actually know him...' This sense of being alienated is also evident in Anne's comment that when she finally took her son home she no longer felt that she was '...babysitting somebody else's child'. Sandra felt so much that the baby was not her child that she got to the point where she wanted to stop seeing him and let the hospital alone deal with him.

The procedures of the unit were in stark contrast to those earlier natural birth expectations considered in Chapter Four. For some women these had included ideals of an environment defined by its happiness, that being defined by the presence and holding of the new baby. This further shattering of expectations formed an important part of their experience of pre-eclampsia.

As well as feeling alienated from their babies, nine of the women told of their distress at being placed on postnatal wards with mothers who had their babies with them. Being amongst others who had their babies with them brought into sharp focus their own situation and added to their distress.

'I was put into a side room but it was right next to the ward where people had all the babies with them. You were expected to go to breakfast with people who had their babies with them...I did find that fairly difficult because they were all talking about the babies and I didn't know whether mine was going to live or not. I did find it very difficult.'

(Brenda)

'At first I was given a bed on the main ward with mothers who had full term healthy babies...I naturally wanted to stay apart from the other mothers but was forced to take meals with them. I even ended up talking to someone who informed me that she'd had a baby in special care that had died.'

(Jane)

There are many reasons why a baby may need the medical support of a neonatal unit. Undoubtedly, some of the issues above relate to mothers of all such babies and the issue of the organisation of neonatal care, including its physical location in relation to postnatal wards, and the specific needs of mothers with babies in such units, is a generic one. Recent research has, for example, been concerned with exploring parental experience of information sharing in the context of increasing pressure to assure informed consent throughout the care management of babies (Alderson, 2006). Whilst the basic aim of my

research was to explore the experience of pre-eclampsia, in the overwhelming majority of cases it was an experience intertwined with dealing with a sick baby. Pre-eclampsia was not just about a woman's own physical sickness. It was, in their accounts, a story of their ill babies and their experience of neonatal care.

Others

In telling of their experience of pre-eclampsia, women told not only of their own physical and emotional pain and of their experience of dealing with babies needing neonatal care, they also spoke or wrote about their partners, husbands, parents and sometimes other children. They did not see themselves as 'pregnant patients' (Graham and Oakley, 1981), but as wives, partners, daughters and mothers. They accounted for the emotions and needs of these others whilst they were hospitalised and receiving medical care. Nineteen women spoke directly about their husbands or partners. They told of the role they played practically and emotionally during the crisis. They accounted for them emotionally and they told of their role in 'telling' them about the crisis in situations where illness meant that the women themselves were not in a state to comprehend events.

Supporting, Protecting and Advocating

Women told of how their husbands, partners and parents supported them. Sometimes this support took the form of them emotionally supporting their wives or partners. Jane for example described her husband as being '*calm and supportive*'. Carol's baby had to be delivered by caesarean at thirty-two weeks because of pre-eclampsia

'Well [husband] was very good, my husband was brilliant and when [son] was born he was positive, he just said yes he is fine and you are fine. He is just a bit small and he is just going to be brilliant and he was fantastic. He was just good support and that's why I forced myself to get better for him and the baby and for me really.'

The support provided was also practical. Some women reflected on the role of their husbands and partners in looking after the babies whilst they were too ill to do so. After giving birth to her son early because of pre-eclampsia, one woman became even more ill.

'It was whilst the paediatrician was examining [son] that I realised I had disturbed vision. I also felt very sick and vomited...I was transferred to intensive care at the John Radcliff hospital as it had become apparent I had developed acute renal failure and liver failure. HELLP syndrome was diagnosed. [Her husband] was going to special care baby unit in the mornings to visit and help care for [their son] and then he would visit me later in the day, a forty mile journey each way.'
(Nadine)

Such support often had its own consequences. For some women, the consequences were negative. For example, Diane suffered pre-eclampsia three times. When hospitalised there were always other children to be tended to. She described the results as a '*separation*' in that he could see the children after work but not drive to hospital to see her too. Julie's husband also had to take over the care of their son as she was simply too ill. She felt however more positive in that it encouraged him to be more than the '*...kind of dad sitting watching...*'

As well as supporting them, some of the women explained how their significant others had protected them. Terri's husband, for example, did not tell her just how ill she had been and that it had been at one point a possible choice between her and the baby. He protected her from such knowledge until a year after the event knowing that at the time she was not strong enough to deal with it.

Some accounts show the advocating role of others. Brenda was hospitalised on several occasions before her baby's birth with a variety of symptoms that would subsequently be understood as those of developing pre-eclampsia. She described how she would seek the opinion of her husband and parents regarding the symptoms and the hospital's treatment of them. She raised issues with them that she did not feel able to bring to the staff. It was, for example, her husband who '*had a word*' with staff on the post natal ward concerning the Brenda's postnatal 'blues'.

'Telling'

Some women were too ill to know exactly what was happening to them. The divergent roles of women and their significant others during the crisis was summarised by one woman in terms of their significant others '*...being dragged through it completely sober*' whilst she did not know '*...what was going on most of the time.*' (Lorraine). Significant others in these situations would be witnesses to what was happening and some women described how they relied on them to 'fill in' the story of their experience. An example of this is revealed in Terri's account. She suffered kidney and liver failure through pre-eclampsia and was in intensive care for three days. Just prior to this acute crisis her husband was told she had pre-eclampsia. As mentioned previously, he decided to keep that knowledge from her on the basis of believing that such awareness would hinder her recovery.

'It was only at the six week check that I realised how seriously ill I was. It was then that I felt I needed to talk to somebody about it although [husband] was really good. I was out of it most of the time. I wasn't awake. So he knew and I kept asking him questions...'

Bella suffered an eclamptic fit and spent some days in intensive care. Her parents were in her hospital room at the time.

'It was a great shock. It took me a long time to get over it because I didn't know what went on because I was sedated it was difficult. It was only through people telling me, like my parents who were in the room with me when I fitted....they would talk to me about what happened...'

Feeling

Many women considered the impact of the illness upon the emotional state of their loved ones, be it their husbands, partners, children or own parents. Fran described her husband as experiencing '*shock and disbelief*' at her illness and subsequent early delivery. Some related this emotional distress to the fact of their '*being there*' and supporting them.

'I never worried about myself ever...but he did and he would have the worry, he still had work, trying to do an all days work and then come up and visit me and find out what he could find out'
(Linda)

The fact of their 'knowing' was also recounted by some women as causing their significant other's distress. Some women felt that this was often marginalised by the medical professional and that they too needed support. For example, Pat and her baby were given only a fifty per-cent chance of survival after suffering from pre-eclampsia in her fourth pregnancy. She describes her husband as being '*petrified*' and felt he did not get the support needed.

'...I know he didn't get the support because (they) always ask how mum is doing, how baby is doing, not how is dad doing or anything like that.'

The trauma led to him choosing to have a vasectomy for fear of it happening again. Sandra's husband blamed himself for her illness. Not understanding the cause of it, he assumed it was something to do with him. She reflected upon the worry he must have experienced, not knowing if she was coming home. He too had a vasectomy through fear of it happening again.

It was not only husbands and partners who women wanted to account for emotionally. Pat, for example, also reflected on the experience of her illness upon her other children and the need for her to get them back as a family unit.

'...it was hard on the other children, as well as going back and to knowing they had got a little brother there but they couldn't hold him'

Carol also spoke not only of her husband's emotions at the time of her illness but also of her parents. She felt that they *'...just couldn't cope with it'*

'I think she (mum) was quite shocked to see how ill I really was and I had to force her to go down and see the baby because I wasn't very well. She went down to see him and we almost had to push her through the door...people had sent cards but my mum hadn't sent anything, not a thing and it was quite a few days afterwards and she said I hadn't brought anything because I didn't think it was quite appropriate, thinking that he was not very well and he was going to die.'

When women spoke or wrote of their experience of pre-eclampsia, they told also of the role of their husbands, partners and parents. They told of their role in supporting them

through the crisis and of 'telling' of things that happened where they themselves were not conscious. The women also accounted for their emotional experience throughout the illness. My findings are similar to those of Bondas-Salonen (1998). Her research carried out among Finnish women recorded the role of their husbands, as expressed by the women, as supporting them to alleviate anxiety and the women's belief that they too were in need of care.

Women's recounting of their experience of dealing with hospitalised babies and their accounting for other significant others, as well as the general subjective consequences of experiencing a pregnancy transformed from assumed normality, demonstrates clearly that pre-eclampsia did not render the women in the research as mere patients in the narrow sense often associated with the medical model. Feminists have rejected the idea inherent in the medical model of women as 'pregnant patients'. Alternatives have been promoted that recognise the many statuses of women. The findings of my research support this. However, in doing so they further demonstrate the problems of existing analyses which marginalise the fact of problematic pregnancies because in failing this they fail to analyse how the rendering of such women as pregnant patients also conflicts too with their lived experience.

Summary

This chapter has attempted to provide an insight into women's experience of pre-eclampsia at the point where medical concern was shown and intervention a consequence. This transition into a pregnancy defined by abnormality was defined, not only by physical problems but related emotional trauma as their expectations were shattered. I began by tracing the normalisation of symptoms into the situation whereby women would be

medically recognised as having a serious problem with their pregnancy. Understanding why some women even at this stage did not locate themselves within the context of abnormality, it has been argued that this is explained both by the physical nature of the disease which can be 'hidden' but also the wider context within women assumed themselves to be risk free, this having been initially considered in Chapter Four. I have suggested that the significance of notions of risk were again identified in the accounts of women who experienced feelings of guilt. The significance of this in relation to my overall attempt to develop the feminist contribution will be considered in Chapter Eight.

Women's accounts of their experiences also illustrate the way in which the physical body and the experience of it are intimately connected to the social context in which people are located. Not only is the pain that can be caused by pre-eclampsia experienced and responded to in various ways dependent upon factors like existing ideas about the pain of childbirth, but the bodily distortions are subjectively experienced negatively insofar as they contradict notions of normal and expected pregnant physicality. I have suggested, therefore, that some of the issues emerging from the data illustrate the insights developed from the sociology of the body,

I have suggested in Chapter Two the importance of exploring the subjective experiences of women who experience serious pregnancy complications given the tendency of existing contributions to leave unchallenged 'pregnant patienthood' in such contexts. This exploration has begun in this current chapter. Given the subjective and physical elements of the experience of pre-eclampsia, is a successful personal experience possible to realise within a context of necessary intervention? In support of existing critiques of medicalised childbirth I have shown how, far from being isolated patients, women do have a concern with wider issues than their own physicality. Partly this is revealed in their reflections on the care they received. Whilst thankful for the physical care and understanding of the

reasons for the limitations in responding to their wider needs, these wider needs were considered important. Women's own centralisation of subjective elements of their experience is shown, not only in their reflections on care received but also through their accounting for others. The latter part of this chapter identified the ways in which women accounted for those who were most with them during their illness. Women described the supporting and advocating role of their partners and husbands for example and spoke or wrote of their concern for their emotional wellbeing. It was their want to tell of these others that influenced my decision to include some of them in the research. The accounts of these others are now considered in the next chapter.

Chapter Six

Unheard Voices

When I began this research it was with the firm intention of understanding women's experiences of pre-eclampsia. Early interviews made it clear that in telling their stories of the illness, they also wanted to tell how it impacted upon their kin; they spoke of their husbands, partners and parents. The women's experience of pre-eclampsia was not an experience that occurred or could be fully understood in isolation from other people in their lives. After the initial interviews, I began to see that the accounts revealed the influence of these significant others upon the women's understandings of pregnancy and their response to abnormality. This has been to some extent already considered in Chapter Five. Some women believed that partners and others had been so tied up to the experience, that their voices were also legitimate. They suggested that I speak to members of their kinship networks because of their role in 'knowing'. Some women had been so seriously ill that aspects of their illness and care they simply knew nothing about. Their families did.

I had approached my research aligning myself to feminist commentators who criticised medicalised childbirth for constructing women as essentially *patients*, the main focus being their physical morbidity and mortality. The previous chapter testified to the fact that the women in my sample, whilst having experienced a situation of necessary obstetrical control, voiced wider issues and expressed concerns for their significant others. This suggested that their experience of pre-eclampsia went beyond that of a physiological and subjective experience of self. With a desire not to engage in the same assumptions about women being isolated patients and with the need to explore how women's care situations

might be improved, I decided to include the 'unheard voices' of some of these 'others'. My exploration of these is explored in this chapter.

I thus wrote to all women in the sample who had returned the questionnaire and indicated person or persons they considered had been 'most with them' during their experience of pre-eclampsia requesting permission to contact these people (Appendix 8). If they gave their consent, they stated their relationship to such a person/s and supplied a contact address (Appendix 9). I then contacted these people giving them information about the nature and purpose of the research and sought their direct consent to take part (Appendix 10). Eight replied that they would, though of this only six accounts were then actually collected with two of their partners/husbands deciding not to participate. Three of these accounts were collected from women's mothers. One interview was conducted and two written accounts provided. Three husbands also agreed to participate. One was interviewed, another sent a written account and a third sent the diary that he had written during his wife's illness, up to the death of his son. The intention was to explore several issues. Firstly, I was interested in how these family members emotionally experienced the illness. Secondly, I was interested in how they themselves 'made sense' of pre-eclampsia. I also wanted to explore their perception of the medical care and support that their daughters or wives received and their thoughts about the reaction of the medical professionals to themselves as 'significant others'.

My analysis of these accounts is presented below in two parts, firstly, considering the accounts of the women's mothers and then those of the women's husbands. A brief reminder of the situation of their daughters or wives will be presented before the consideration of these accounts in order that the reader might understand the situation with which these significant others were faced.

Mothers

Andrea is Linda's mother. Linda experienced pre-eclampsia twice, the first time at twenty-nine weeks, and had given birth at thirty weeks, the second time being diagnosed at twenty-six weeks, giving birth at thirty-three weeks. Her first child spent five weeks and her second, three weeks in a neonatal care unit.

Jane is Terri's mother. Terri was thirty-six weeks pregnant when she had to have a caesarean. She was not informed until after birth that she had been diagnosed with pre-eclampsia. She spent five days in hospital and her baby required no neonatal nursing care.

Rose is Mary's mother. Mary was diagnosed at twenty-six weeks and had her baby at twenty-nine weeks. She was in hospital for four weeks in total, three before the birth by caesarean.

These three mothers' experiences of their daughters' pre-eclampsia were influenced by the ways in which they positioned themselves in relation to their daughters and others within their daughters' network of social relationships. The data reveal three positions. These are not mutually exclusive insofar as each woman often inhabited more than one. They are analytically distinct, however, insofar as their accounts reveal differences in the types of action and interaction related to them and the tensions which may exist between them. These three positions I have called 'with daughter', 'marginalised mother' and 'with baby'.

'With daughter' describes the position in which the mother expressed and reaffirmed her emotional identification with her daughter. This identification was first made evident in

the way in which they described their emotional involvement in their daughters' pregnancies. Linda's mother, Andrea, wrote of her '*excitement*' when her daughter told that she was expecting her first baby. Another mother expressed her emotional identification with her daughter by reflecting upon the mother/daughter relationship. Speaking of her reaction to her daughter's illness which necessitated a caesarean, Jane said:

'After all's said and done, that is your baby that's giving birth.'

All three mothers' accounts express a particular identification with the women because of their relationship to them as mother. The emotional investment in their daughters' pregnancies also led to a belief in their particular ability, compared to other kin members, to understand their daughter's predicament. Rose's written account expresses this well.

'No one can understand like a mother...Unfortunately my husband is not very supportive nor indeed was [Mary's husband]. I feel I gave her all the support I could.'

Chapter Four revealed the way in which women's expectations of pregnancy were influenced by the way in which their referral network, including their own mothers' experience, led them to marginalise risk or to conclude the importance of it. One of the mothers' accounts made very explicit the way in which she also constructed her daughter's pregnancy partly through notions of risk deduced from her own experiences. Andrea assumed the normality of her daughter's pregnancy.

'My own pregnancy with her had been very straightforward, with no complications at all, so I expected her pregnancy to be very much the same.'

When her daughter, Linda, was told to go to hospital Andrea was the one who drove her there. Even at that point her expectation of the normality of her daughter's pregnancy was

sustained.

'When she was 29 weeks, she phoned me at work to say that she had to go to hospital, could I take her as her husband was away ...Her BP was high and I believe she had protein in her urine. I was not concerned at this stage, so I drove her to hospital.'

In comparison, Rose herself had suffered pre-eclampsia. This experience led her to worry particularly when her daughters began to develop symptoms that she recognised as problematic.

'More or less at the beginning of [Mary's] pregnancy I was worried as she had swelling of her hands and feet... I myself had pre-eclampsia when Mary was born. I was therefore devastated at the news and worried constantly throughout the pregnancy'

Mothers identified emotionally therefore with their daughters' pregnancies but did this in relation to their own expectations regarding pregnancy outcomes, whether these assumed normality or the fear of possible problems. This emotional identification with their daughters is also revealed in the way in which the mothers accounted for their daughters' actions and emotions. Andrea, for example, reflected upon the emotional impact the illness must have had on her daughter.

'It was not until (son) was born that we realised how ill Linda was. She must have been very worried but did not want to worry us too much. I think she tried to hide her feelings'.

Rose wrote of her daughter's 'bravery' going through an illness and being told that her baby might not live. She describes her daughter's illness as '*...the most awful thing to go through*', her empathy strengthened by her own previous experience of the illness. Jane also accounted for her daughter's husband's feelings.

'... [Terri's husband] is adamant he doesn't want anymore children because of it, he doesn't want to go through all that again and I keep trying to say to him well they know, they will monitor her really carefully the next time...I think she would like to have another one but he has got a barrier up I suppose because he saw it at first hand...'

As well as accounting for their daughters' emotions and behaviour, these women's position of '*with daughter*' reveals itself in the nature and expression of actions they took or wanted to take. These included practical actions and those involving advocacy. Linda developed some symptoms at twenty-nine weeks gestation but returned home after a short hospital stay after her condition was stabilised. Her mother wrote about how she helped her daughter with all of her housework because of '*not wanting her to do anything*'. Terri's mother moved in with her after she and her son returned from hospital. As well as this practical help, her role as advocate for her daughter is revealed. For example, she would ask the community midwife the questions that her daughter had forgotten to ask. More explicitly, Terri's mother was unhappy at the care received by her daughter and spoke of her wish to challenge those responsible for her care. For example, she would have wanted to:

'... (go) up to one of the nurses. Why are you leaving her so long? Why can't you just take her in and get this baby out one way or the other?'

She did not make this challenge. In revealing why, a second location becomes visible: that of what I have referred to as '*marginalised mother*'.

In this position, mothers assume the role of '*witness*'. Although present they become marginalised in terms of their involvement in the actions and interaction surrounding their daughters. It is here that the tension between this and the previous location becomes revealed. In accounting for why she had not made the challenge regarding her daughter's care, Terri's mother, Jane, said:

'...I didn't want to be seen as an interfering mother'.

Marginalising herself averted the negative cultural stereotype of the 'interfering mother'. In doing this however, she had to suppress actions associated with being 'with daughter'. This self marginalisation was also conditioned by her assumption of the husband's privileged advocacy role.

'I didn't want to go over his head...I probably could have done [ask questions] but then like I said I didn't want to interfere and it was her first child and I thought [Terri's husband] would have...'

The hospital itself was also implicated in the reproduction of this mother's self marginalisation.

'...the thing with hospitals, the husband is always important, unless it's a single woman then the mother's going to be there. If the wife has got a husband then the mother does get pushed to one side a little bit...It would have been nice for a midwife or nurse perhaps to explain to me what the implications were and what was the initial outcome afterwards, was it a speedy recovery or whatever.'

Jane reflected on how it would have been good if staff had explained to her what the implications were. The apparent tension between the positions of 'with daughter' and 'marginalised mother' did not, in this case, erupt in conflict. The potential however is there. According to Jane, in subsequent pregnancies she would be less willing to be 'pushed to one side'.

Andrea wrote also of her self marginalisation in terms of gaining access to information concerning her daughter's illness and her role as *supporter*. This seems to be based upon the assumption that mothers should reposition themselves once a husband is on the scene. Andrea reflected on the extent to which she had felt informed about her daughter's

condition in relation to what her daughter chose to share with her.

'...obviously (Linda) did not discuss with me every single stage and the many discussions with the doctors and nurses. I respected the fact that she had a husband to talk to and obviously they helped each other to cope with this in their own way.'

Mary's account did not fall into the 'marginalised mother' category. A possible clue as to why Mary's mother's account seems to deviate from the other two in this respect might be suggested in her comment, already noted above.

'Unfortunately my husband is not very supportive, nor indeed was (Mary's) husband. I feel I gave (Mary) all the support I could.'

Perhaps the limited role of the 'marginalised mother' location becomes less evident in situations where, despite the presence of other 'significant others', the 'with daughter' role becomes an invaluable social and emotional resource.

A third position of the women's mothers revealed in these accounts is one wherein their mothers begin to identify and focus upon the issues and problems surrounding the baby. Their accounts make frequent reference to their worries and fears concerning the baby. In Andrea's account the changing emphasis from being 'with daughter' to 'with baby' was very explicit.

'Once he had been born I suppose he was my main concern. This seemed to take over my whole life. I could not talk about anything else and had to talk to [daughter] everyday to find out how [baby] was.'

For Terri's mother this repositioning into another location, that of *with baby*, was slower to develop. In describing her feelings about visiting her daughter and the baby in hospital

Jane said:

'...they let me go in there to see the baby. It wasn't the baby I was actually interested in...it was her. He is special to us now I must admit'.

Thus, in the context within which they found themselves, mothers occupied various positions which defined the way in which they experienced their daughters' illness. Whilst these were not necessarily exclusive of each, they seem analytically distinct in terms of their differing expected and accepted forms of action and interaction. Two of the mothers told of a sense of their being marginalised in some way due to the assumptions about the role of their daughters' husbands. The women's mothers were also emotionally attached to the babies and they too experienced the worries and anxieties that the early birth produced. All three mothers expressed an emotional identification with their daughters' pregnancies and their own experience influenced their expectations of the pregnancy. In Chapters Four and Five I argued that the women's construction and maintenance of a sense of the normality of their pregnancy emerged in part through their awareness of the experiences of significant others and through their referring to such people for advice, including their own mothers. In the accounts of these others we can see evidence of this process whereby experiences of pregnancy affect expectations of pregnancy.

Three husbands' accounts were included in the primary data collection. How did they experience their wives' illness? In what ways do their own accounts reveal the role they played as earlier considered through the women's own accounts of the role of their significant others (Chapter Five). I begin an exploration of their voices by reminding the reader of their wife's situation.

Husbands

Alex is Angela's husband. Angela herself was unable to contribute a full account to the research but sent me some notes on her aftercare and completed the research questionnaires. She was diagnosed with pre-eclampsia at twenty-eight weeks and would have an emergency caesarean. Her son survived for five days before dying of complications of prematurity. Alex sent me a detailed diary that he kept during Angela's and his son's illness.

John is Fran's husband. Fran was diagnosed with pre-eclampsia at twenty-eight weeks gestation. She had to have a caesarean and spent two and a half weeks in hospital. Their daughter was in neonatal care for eight weeks before being discharged.

Steve is Belinda's husband. Belinda was diagnosed at twenty-eight weeks but actually had her child through caesarean at thirty-four weeks. Belinda spent seven and a half weeks in hospital and their son was in a neonatal care unit for three and a half weeks before being discharged.

Two of the three husbands had never heard of pre-eclampsia prior to their wives' diagnosis. Andrea's husband, Alex, described how when she was diagnosed with pre-eclampsia at twenty-eight weeks gestation, it '*...meant nothing' to them*'.

'I didn't realise the seriousness of [Fran's] illness and the effect of pre-eclampsia. In hindsight she did swell up all over her body and her face but I didn't think anything of it at the time.'
(John)

Fran is a nurse and John also reflected on the way in which this role empowered her.

'A registrar came in to see her and an anaesthetist, who kept saying there was nothing they could do for her although she knew she was retaining fluids and was struggling to breathe. Something only eventually got done, by being a nurse and insisting that she was given a diuretic...'

The knowledge that empowered her in this context, however, was the same professional knowledge that marginalised John from many conversations and therefore from an understanding of Fran's condition.

'Being a nurse, the medical staff spoke to her in medical terminology which went straight over my head. On very few occasions did they speak to me in layman's terms, as usually [Fran] translated it for me.'

Conversely, Steve felt very informed of his wife's condition and included in discussions and decisions. He considered, however, that the level of information shared was not universal but rather depended upon the professionals' view of him and Belinda as being *'not daft.'*

'I think they realised that both (Belinda) and I were not daft and they gave us quite a lot of detailed information and knowing that we were understanding it and taking it in, they were prepared to give us lots of information.'

His account, along with John's, suggests the way in which information sharing might sometimes be contingent upon professionals judging patients and their significant others in terms of their ability to understand. Steve also felt, however, that the extent to which he and his wife were willing to conform explained the extent to which professionals engaged with them.

'...they kind of lightened up after a while once they knew that we knew the rules...'

Steve considered their experience as 'positive' and that this was rooted in their willingness to help themselves, which he defined in terms of listening and conforming. It might be suggested that this reflects the highly medicalised context within which they were located, where there is even little room for preferences and opinions but instead more of a requirement for conformity to established ideas about procedures. A tension emerges through his account, however. Steve's assurance was founded upon his understanding of his wife's and child's condition, this understanding being dependent upon the medical profession's sharing detailed information with him. He trusted their expertise, especially in the context of Belinda's constant supervision.

'...as long as they kept their eyes on things, it was all going to be okay. We know [she] was in a severe state but I kind of assumed they had ways of dealing with it if anything went wrong...but given they had been watching her like hawks for four weeks, I didn't expect that they were going to screw it up at the last minute you know, even if her symptoms after the birth still got worse...I assumed if it got worse during that period, they would have ways of dealing with it...'

However, this trust was conditioned upon not just what was being told him, but what he was witnessing. Steve 'watched' events to gain assurance. When his son was born he firstly stayed some time with his wife.

'I think I just got to the point where I worked out all the nursing staff had done what they were supposed to...I went and saw him; there were nurses there looking after him, so there was nothing to worry about that end...'

Some of the women had reflected critically upon the lack of support received by their husbands and partners. Two of the husbands, however, told of their experience of the support that they themselves received. Steve did not feel the need for any professional

support. His understanding of what was happening was 'enough' for him. Steve felt that if he had required support, he would have been able to ask for it. However, his expectations of it were constrained by his knowledge of the available resources. Asked whether he felt he had enough support, he replied:

'Yes I think so. I don't know if I would have been that confident that there was anything there to go to. I don't know that's probably just my guess. I think the straight physical type nursing is pushed to the limit. My guess is the resources made available to psychological type nursing, I would guess there is even less of that available...I wasn't expecting anybody to be there.'

As mentioned earlier, John struggled to understand what was happening to his wife, a situation made worse by information primarily being shared using medical terminology because of his wife's status as a nurse. John wanted more support and it seems that it was his wife who made suggestions that would help him to adapt to what was happening. For example:

'There appeared to be very little support for partners...and no information about pre-eclampsia. I went to the special care unit before the birth, only on Fran's suggestion, which was a good one. This prepared me (a non medical person) for seeing a tiny baby with loads of monitors and wires around it.'

Chapter Five has already shown, through the accounts of the women, the role played by significant others in supporting them. The husbands' accounts give further illustration of the nature of this support. Steve for example was aware of the difficulty faced by Belinda as she spent over seven weeks in hospital.

'...I used to try and break her day up by going in for a couple of hours in the morning from whatever time they let visitors in...do a couple of hours work then come back lunchtime, twelve to anytime, two or three, because it was only a five minute drive away...I thought she might go a bit crackers...'

The location of his work and his relationship with his employer allowed him to do this.

Alex told his wife of their baby's impending death. He wanted to be the one to tell her.

His account tells of the mutual support he and his wife provided for each other.

'We went back to the SCBU flat and had a good cry. We then had the terrible phone calls to make home. I broke down on the phone to my brother, Andrea broke down on the phone to work. It is strange how for the next couple of days, we took it in turns to be strong. Often if I broke down (usually on the phone home) Andrea would relieve me and vice versa.'

The accounts of all three men illustrate many different emotions as they experienced their wives and babies being seriously ill. Steve's knowledge of what was happening and trust in the medical professions made him less wanting of particular support. Early in the interview he described himself and his wife as '*pretty laid back people*' who could deal with hospitalisation. His later reflections however suggested a real worry and concern and a changed definition of himself and his coping abilities.

'I try to rationalise a lot of things, but I still knew that it was pretty severe and that it could take a turn for the worse if they didn't keep an eye on everything...I am not that laid back really, So the fact that she was in a bit of danger at that point concerned me a lot. I don't know how you quantify your studies particularly, but I can always quantify mine in whisky and coke. But I wasn't going to go off to sleep easily because my mind would be running rings around me thinking what could happen, so in order to combat that I would have a whisky before I went to bed. Almost knock out drops.'

The above was shared with me over half way through the interview and in trying to make sense of the apparent contradiction with his earlier descriptions of coping; I suggest that it may have simply been a product of his feeling more at ease with me as the interview progressed.

John's account was a written one and this might explain the greater ease which he

seemed to have in expressing the emotions he experienced. John moved from disbelief and shock at what was happening to a sense of helplessness.

'You do feel helpless as a partner in a situation like that though, as Fran was obviously in a lot of pain due to pre-eclampsia, but there was nothing I was able to do to make her feel better.'

Chapter Five considered how some of the women had developed a sense of being alienated from their babies due to the latter being kept within a neonatal unit. John's account illustrates the way this may also develop amongst the fathers of such babies.

'We both felt it difficult to believe that she was ours being separated and looked after by other people and we went to see her because we felt we should, which sounds awful.'

Likewise, Alex's son spent six days in a neo natal unit before dying of complications. He too reflected on a feeling of alienation.

'I think this was one of the most difficult things not being able to have any physical contact with [him]. I know it was not possible, that he was better off where he was but it was hard. I actually felt quite detached from him at first, not really feeling that he was mine...'

Chapter Five considered the way in which for many women, their experience of pre-eclampsia contradicted their early expectations and hopes regarding pregnancy and childbirth. In Alex's account we also see the way in which fathers too can hold expectations regarding fatherhood which are then equally shattered. After the birth of his very sick son:

'I went for a walk along the front, desperately struggling to come to terms with

what had happened. I went for a pint in the Pilot Boat but I hated every minute of it. This was not how it was supposed to be. I was a father and I should have been overjoyed but instead I just felt shocked and sad.'

Just as flowers and congratulations cards constitute a cultural ritual for a new born child, so too does 'wetting the baby's head' or having a drink to celebrate the birth. The reality of this celebration for Alex deviated greatly from this. In his own way however, Alex was able to express a father's pride in his son. His account makes reference often to this pride. From an initial feeling of being alienated from his son, Alex developed a strong bond with him and was '*proud of the way he fought against all the odds*'.

The three accounts of husbands show the degree to which they were intimately bound to their wives' experience of pre-eclampsia and its consequences. Like many of the women, some of these husbands knew little about pre-eclampsia. One was positive about the level of knowledge shared by the medical profession and explained this in terms of their perception of him as not 'being daft'. None of the husbands received any professional support. Their role in supporting their wives and the many emotions experienced was made evident in their own accounts. Some of these emotions, like that of feeling alienated from their baby were an emergent theme in the women's own accounts. The men also held ideals and expectations of pregnancy and birth and it is in Alex's account that we see this most vividly expressed and shattered.

Summary

In response to the women's own challenge to me, I sought to hear directly the voices of those that have hitherto remained largely unheard. In Chapter Five the way in which women experienced their illness as wives, partners, and daughters, and in some cases

mothers, identified the importance of understanding the experience of pregnancy complications in terms wider than that of their individual patienthood. The insight this chapter has been able to give into the perspectives of these previously unheard voices testifies further to this. The women themselves had told of the role of 'others' in supporting them and being in some cases a 'witness' to events. The 'others' themselves also tell of this role. Some women felt that these 'others', especially their husbands or partners, had their own care needs given the context within which they also found themselves. Their own accounts also provide some evidence of this.

No research has been conducted on how mothers experience their daughters' pregnancy complications. There has however been much research on the role and experience of the father during pregnancy (Draper, 2003) and the experience of medical technology during childbirth (Williams and Umberson, 1999). Studies have also been conducted on the way in which fathers experience stillbirths and neonatal deaths (McCreight, 2004). However, no research has specifically focused upon the experience of men during serious complications of pregnancy. The sample of men and the women's mothers from which this chapter's exploration has been generated is very small and unrepresentative, making generalisations impossible and conclusions circumscribed. Nevertheless, they are significant in any understanding of women's experience of problematic pregnancies. They are quite simply part of that experience. Feminists have already challenged the idea of 'pregnant patienthood', that is the idea that women's experiences can be understood and dealt with as though they were devoid of social and emotional characteristics, especially that defined by their many statuses. This chapter develops that point in relation to problematic pregnancies. Indeed, it is this one-dimensional conception of childbearing women that remains largely unchallenged in situations of serious complications. I have attempted to show in this chapter the need for researchers to look beyond challenging the assumption of 'pregnant patienthood' in situations of normal pregnancy and birth, to challenge that

assumption in situations where the dominance of the medical model would legitimate it.

Chapter Seven

Post Pre-eclampsia: Reflecting and Accounting

One of my research objectives was to explore women's changing understandings and ideals of pregnancy and childbirth through the lens of women's social and emotional experiences of problematic pregnancies. These changes are explored in this chapter through the ways in which they reflected upon and made sense of their experience of having had a medically defined abnormal pregnancy. I was interested in exploring three questions with the women. What was the emotional aftermath of the disease? In what ways, if any, had it changed their perception of pregnancy? Thirdly, what ideas did they have about any possible service improvements? Having already examined the construction and nature of early images of pregnancy in Chapter Four and the impact of these on their understanding and response to developing symptoms in Chapter Five, I wanted to understand, secondly, whether or not the experience of pre-eclampsia would lead to a reconstruction of those images and if so, in what ways and with what consequences. The third question emerged from a desire to 'give voice' to women at the level of care provision.

The first section of this chapter considers the emotional impact of pre-eclampsia in the post-illness period, specifically the time after they had been discharged from hospital. This period was characterised for some of the women by the need to deal with ongoing resultant physical problems. Women were left, for example, with high blood pressure, kidney problems and visual disturbances. Medication regimes and medical surveillance would therefore form part of this time. As a major cause of prematurity, pre-eclampsia often

resulted in the women's babies remaining hospitalised, sometimes suffering from severe problems as a consequence of the illness. Two women's babies died. For others, this period was marked by a time of coming to terms with suffering from a serious illness. It is within these contexts that women expressed how they felt. Fear, guilt and struggling emotionally with their babies were common longer term affects. Some of the women also shared with me their need to understand the illness and its aetiology. I have conceptualised these thoughts in terms of them seeking to develop their own expertise by seeking to gain access to medical knowledge. I will show that for seven of the women who entered subsequent pregnancies, this expertise would be a means through which they fought for control in a context within which medical discourse perpetuated their passivity.

In Chapter Four I began to suggest that whilst women's early perceptions of pregnancy were characterised by notions of its normality and naturalness, these were nonetheless constructed through a risk assessment process. Given this, it would therefore be an oversimplification to claim that the post pre-eclampsia period was characterised by a change from a perception of pregnancy as normal to one of abnormality insofar as notions of risk are nonexistent in the former and central in the latter. Rather, their changing perceptions conclude from a renewed engagement with risk whereby it is now a *central* concept rather than a *marginalised* one. The second section of this chapter describes the dimensions to that risk and women's engagement with it.

Finally, this chapter considers women's own thoughts and opinions on how the care they received could be improved. These ideas locate the need for improvements from the stage of early pregnancy through to the post pre-eclampsia period. Their ideas on improvements can be descriptively categorised as Informing, Supporting and Access to Expertise.

Emotional Consequences

Deviating from the expected normality of their pregnancy produced different negative emotions. A consideration of these reveals more about their expectations of normal pregnancy, as earlier considered in Chapter Four.

Some women grieved over not experiencing what the normative expectation of normal birth had led them to expect.

'I feel that I went through a grieving process really, you know of not actually being normal. Anyone who has a baby has this thing in their minds-that you know you go into hospital, you have the baby, people will come and see you and you go home. Mine was a totally different experience to that.'
(Cerri)

Normal pregnancy for some women also included ideals of physical changes and the social mannerisms that these changes would produce. There was the expectation, for example, that a time would come when the movement of the baby would be clearly identified. These perceptions of bodily changes, the social response they would produce and the effect of such expectations being unfulfilled is illustrated in Fran's account. Fran had looked forward to the time when her baby could be felt moving. However, pre-eclampsia and the premature delivery at twenty-eight weeks that it necessitated thwarted this expected event and its associated social and emotional responses, leading in her case to a sense of mourning. At the time of the interview, three months post pre-eclampsia, Fran was suffering from post natal depression.

'I feel a bit bereaved that I didn't get to the next stage where I was waddling

around with a big hump. People would give up their seats on the train or whatever...I don't think we really got to the really excited anticipated stage, you know where you really feel it moving...I feel I have missed out on something...it's not the birth I have missed out on but something before that.'

When women's early expectations of pregnancy and childbirth were dramatically unfulfilled, not only did this sometimes lead to a sense of grief, but also a sense of failure. The nature of this failure was dependent upon how the women had come to define success. For example, Terri had wanted to experience the pain of childbirth, considering it to be a worthy and defining aspect of childbirth. As defined in the natural childbirth literature as work, pain is the hard labour of childbirth that is rewarded by a child and motherhood. The seriousness of her illness led to a caesarean being performed.

'I wanted to have a natural birth, I did put it in my notes, however it was not going to be but I did want a natural birth and of course all that went straight out of the window. I had failed myself because I wanted to go through, it sounds really stupid, I wanted to experience the pain...'

In Chapter Four I showed how for some women a normal childbirth was a birth without the need for a caesarean, consequently such an intervention becomes a failure to achieve. Ellen, for example, considered that '*...to have a caesarean is failing...*' and had planned what she considered to be a natural childbirth. She was unable to carry to full term and give birth naturally because of pre-eclampsia and described herself as '*...being a failure and not being a proper mum*'. The sense of failure tended to be expressed, as with the previous example, in relation to their children. Indeed, it might be suggested that their responses represent a failure to achieve the first test of motherhood. Two further examples illustrate this.

'Every now and again I think that I have failed them in a way and I think of women who have given birth normally and [think] why couldn't I do that.'
(Suzanne)

'I didn't ever think; oh look what you have put me through. In fact it was probably the other way round-I am really sorry that my body failed you...'
(Anne)

Expectations of an uncomplicated pregnancy seem in the accounts to be tied to expectations of successful motherhood, which include the birth of their children. The women grieved and felt failures, therefore, as their problematic pregnancies made them unable to successfully express themselves as 'good mothers'. Cultural normative expectations of what good mothers do include their bodies being able to bear their children and convey them safely into the world. By this definition, the women felt that they were not properly the mothers of their babies.

For some, therefore, pre-eclampsia resulted in a sense of failure and grief as it shattered their expectations of pregnancy and birth; for others, a feeling of 'being cheated' emerged. Whereas guilt and failure suggest their own implication in events, a sense of being cheated suggests the impact of external factors or agents. When asked if she felt pre-eclampsia had in any way affected her relationship with her son, Carol said:

'...I kept saying to my mum, I don't feel like his mum...I felt a bit cheated because I never had a really big bump, I never had all the photographs like when the baby is born, the first photo of mum looking really scanty and all that I didn't have...'

'When other mums discuss having their children I feel robbed of that experience...'
(Emma)

Many of the women remained distressed over a long period of time. Seven of the

women, for example, were diagnosed with depression and two with post traumatic stress syndrome. They had already gone through physical and emotional pain and in the post pre-eclampsia period many were left dealing with emotional strains. A common theme in such accounts is the constant remembering of their illness.

'...you do keep reliving it, which is awful. You get round to one day of every week and it all goes through your head again which is not very nice' (Fran)

This was also the case for Pat who had experienced epigastric pain, indicating potential liver failure.

'...one of the nurses said to me when you usually get a sharp pain it means your organs start shutting down. Even now, even though I don't get the pain I still know what it's like you know. I can think to myself that pain and it's as if that pain is reoccurring even though it's not.'

Fearing now for their own health was also a constant issue for some women. Pre-eclampsia had made their mortality more evident and some feared every symptom that seemed similar to those experienced with pre-eclampsia. Bella, for example, had experienced an eclamptic fit and spent three days in intensive care. She described how for several weeks after this:

'I would think, I can't believe I nearly died...it was just that worry every time I had a headache, I thought oh my god, I am going to have a fit.'

In Chapter Five it was shown how some women felt alienated from their baby immediately after the birth and this was in part tied up with the very procedures of neonatal care units. In the weeks and months following pre-eclampsia some women still

struggled with a sense of their baby not really belonging to them and this was particularly the case with women whose babies had spent a lot of time in neo-natal care. A combination of feeling that they were failed mothers and the marginalisation of their mothering within the hospital could result in a sense of alienation from their child. Sandra's baby, for example, was transferred to another hospital.

'I got to the stage actually...where I said, I don't wish to go in there any more, they can just phone me and let me know when they are going to transfer him. I am not going to go again until they transfer him...they can sort him out and they can tell me when he wants to come home and that's it...'

Likewise, Cerri had her son early through pre-eclampsia and spent three days in a high dependency unit. She spent twelve days in hospital, her son, sixteen days. She had previously described feeling alienated from her son because of the physical distance between them in the hospital and the procedures surrounding his care. Her account was mentioned in Chapter Five. This feeling continued for over a month during the post pre-eclampsia period of time.

'After I'd got out of hospital...I didn't feel that when I went down to see him, I sort of felt...as though I didn't know him.'
(Cerri)

This continuing sense of alienation was sometimes replaced with a self defined over protectiveness once the women in the sample were responsible for mothering their child. Cerri's account shows this process.

'I think it's actually made me very protective over him...I wouldn't let anyone really build up a relationship with him because I felt that I'd missed out the first couple of days...'

At the time of the interview, pre-eclampsia was an illness that had happened five years previously and yet she still defined herself as being over protective. She went on to have a normal pregnancy and healthy daughter and these feelings and reactions did not characterise her relationship with her daughter, suggesting an enduring impact of the illness and its consequences upon her relationship with her first child.

Women who felt less alienated from their babies in hospital were those who felt more able to become fully involved in their neonatal care and therefore less marginalised in their mothering. However, this involvement did not create a sense of true confidence in their abilities transferable to the home context. This is shown in Linda's account. Her baby spent five weeks in neo-natal care. During that time she had got actively involved with his care. With his discharge, however, came the fear of being able to take care of him without the neonatal nurses.

'I was absolutely terrified...you always know at the back of your mind that the nurses are there should anything go wrong...the first few weeks were frightening. I was worried that she would stop breathing.'

The babies of two of the women in my sample died. Angela felt unable to provide a full account, though she sent me some brief notes on her aftercare and responded to the questionnaire. Both she and her husband, however, agreed for me to instead be sent the diary he had recorded. This covered the time from Angela's ill health, to the birth and death of their son. His account has been mentioned in the previous chapter. Pauline also lost her baby. She developed pre-eclampsia in both of her pregnancies. The first baby was born at thirty weeks and suffered no major problems. At sixteen weeks gestation in her second pregnancy she was again diagnosed with pre-eclampsia and he was born by caesarean at twenty-eight weeks. He lived for eleven days. After his death a sense of acute

isolation affected Pauline.

'...my whole life just fell apart and no matter what anybody said, I felt as if my life just didn't exist any longer. Sometimes I'd wished it was me. Sometimes I still do but I felt very, very, very alone...I hated life.'

In the weeks and months following his death, her account shows two consequences. One was her inability to be with other babies. The other was the fundamental breakdown in her relationship with her young daughter. Two excerpts from her account will illustrate these points. Three years after his death:

'I find it very hard to deal with people being pregnant. Then when they have their babies and they bring their babies in, [to her place of work], a couple of them think they were doing the right thing by giving me the baby to hold, which is completely the wrong thing for me because I've got such a gap inside me. I disappear off to the ladies to cry my eyes out'.

She also recalled her feelings towards her daughter.

'She stayed with my mum for nearly four weeks...she had to. I hated her being there. She was here and he wasn't. She survived and he didn't. She'd come to me, all she wanted was a cuddle and a pick up and I couldn't. I couldn't have her touching me. In fact I didn't even used to like her in the same room as me.'

Pauline did manage to rebuild her relationship with her daughter. The point was made in Chapter Five that the social and emotional difficulties of having to cope with a baby in neo-natal care or even losing one to complications related to it, may not be peculiar to women who experience pre-eclampsia. Likewise, the problems encountered in relation to their babies in the weeks and months following birth may not be either. However, it is an important part of their experience, demonstrating again how problematic pregnancies and births cannot be understood fully in individualistic 'patienthood' terms, but rather must be

seen as experiences characterised by significant interpersonal relationships, the nature of which must also be considered in any attempt to explore such experiences. This relational nature of women's experiences is also seen in the accounts of some of the women who reflected on feeling a sense of guilt.

Eight women explicitly mentioned feeling guilty. This sense of failure was sometimes relational insofar as it is expressed in the context of 'failing' their children and or other loved ones in some way. Suzanne felt a failure, not simply in terms of the actual birth, but the possible genetic link to pre-eclampsia, increasing the risk to her own daughter.

'I used to feel really guilty with [daughter] because I would think, you are going to get this and I have given it to her...and it's my fault. Every now and again I think I have failed them in a way.'

This sense of guilt also emerged from the unfulfillment of the assumed normality of their pregnancy and the beginning of their motherhood with this child. Chapter Four showed how in arriving at an assessment of their pregnancy as normal, women engaged with some of the possible risk within pregnancy. Some had believed themselves not to be 'at risk' because of being 'fit' and not smoking. When exploring the emotional impact of the disease in the weeks and months following the illness, what emerged were further dimensions of lifestyle which were retrospectively considered as having created risk in some way, thereby producing feelings of guilt. Women expressed guilt in relation to their own life styles, what they had or had not done and how this might have caused the disease. Causation factors identified by the women included working too much, having hot baths, taking a holiday and not controlling stress levels.

'I felt and still do to a much smaller degree guilty about not being able to carry my son full term...I will always feel guilty that I did something to cause it...eat'

or drank something, lifted something too heavy, was too old.'
(Emma)

The process whereby women would come to reconstruct other aspects of their lifestyle as having been 'risky' is illustrated below.

'You know I never drank and I didn't smoke, I didn't really put my health at risk or the baby's health at risk whilst I was pregnant. I may have perhaps, when I look back now, I do remember going into work and on occasions I really shouldn't have been in...perhaps I shouldn't have worked like five full days.'
(Cerri)

It could be suggested that many women entered pregnancy with a sense of the controllability of the process through engaging at some level with known risks and accommodated them. Rather than shatter such notions, it seems as though some women emerged from the illness with a continued sense of its controllability and their own culpability. This becomes evident not only in the way some reconstructed risk, as indicated above, but in some of the ways in which they came to redefine pregnancy, an issue considered further on in this chapter. Others, however, reveal in their reflections a sense of the uncontrollability of the illness. This is seen with respect to fears concerning the possible genetic element to pre-eclampsia and it is from this understanding of part of the nature of the illness that the sense of guilt, like that of failure, is relational. Ellen, at the time of the interview felt guilty about her assumed role in developing pre-eclampsia.

'...there is obviously something in the makeup; there is something between my husband and me. We have premature babies and I have pre-eclampsia...I still feel it's my fault. I hide it away and don't think about it. If I don't think about it, it's not there, but it is and I constantly think about it.'
(Ellen).

One of the issues I wanted to explore as part of my research was whether the experience of pre-eclampsia would lead to a change in women's conceptualisations of pregnancy and birth. This chapter has shown so far how the experience is not one that ends with a woman's discharge from hospital, but rather one that has longer term social and emotional and sometimes physical consequences. Would one of the consequences of this be a shift from an earlier assumption of normality to something different? Or, as suggested at the beginning of this chapter, would a change from an assumption of normality to one of abnormality be far too simplistic a conclusion to reach? Chapter Four showed how the assumption of normality is one constructed through a process whereby women do to some extent engage with risk, rather than one based on the notion of risk as nonexistent. By asking women if and in what way their perception of pregnancy and birth had changed, I hoped to explore how this process might have been affected and with what consequences. By considering also the experiences of those who entered subsequent pregnancies I now consider the impact of pre-eclampsia upon women's perceptions of pregnancy.

Pregnancy as risky

The previous section and Chapters Four and Five has been drawn largely from women's recollections of their experiences and its consequences. This section considers more directly their conceptions of pregnancy at the time of interview or account writing. As well as considering how women now approached potential pregnancy, the accounts of those who actually entered subsequent pregnancies, of which there were fourteen, are explored in order to understand the lived consequences of such changing perceptions.

All the women reconceptualised pregnancy with hindsight in a way which now

distanced it from notions of normality and naturalness, perceiving it instead as an inherently risky phenomenon. For example,

'It has made me realise that it can be dangerous...I didn't think you could die from it or come out with serious health problems.'
(Lorraine)

For others, pregnancy was something 'natural' for most people but which could also go wrong.

'I thought that you fall pregnant and have the baby not knowing so many complications can occur. You think that pregnancy is the most natural thing. Which it is in one sense but it definitely doesn't run smoothly and it can be life threatening. It's only because of the kind of doctors today and where we are in medicine that probably a huge amount of women and babies have survived.'
(Julie)

Chapter Four showed how the assumption of normality which underpinned the early images, was not constructed in complete isolation from notions of risk. Many women arrived at a sense of normality after engaging in an assessment of the risks. These risks included medically defined ones like the risk of Down syndrome but sometimes those risks conveyed through definitions of natural childbirth, like fear of not being able to control pain. However, the knowledge of risks was circumscribed so that not all medically defined ones were made known, like that of pre-eclampsia. Sometimes, risks were marginalised by the women and generally the manner in which their engagement was then mediated by other influences led women to conclude that their pregnancies were essentially 'risk free'. Pre-eclampsia, however, brought back the reality of risk to these women's lives. Their changed conclusions emerged from a renewed engagement with risk whereby it became a central rather than marginal notion. Women responded, however, differently to this risk. I have conceptualised these responses as 'avoidance', 'safety in medical surveillance' and 'safety in self management'. It is in exploring these different responses that the liberating

potential of certain strategies, revealed in their accounts, may be discerned. That is, suggestions of ways of empowering women who experience problematic pregnancies can be isolated through the ways in which some women came to respond to and deal with risk in subsequent pregnancies.

Pregnancy as Risky: Avoidance

Six women decided that pregnancy for them was simply too risky and should therefore be avoided in future. These women spoke or wrote of fear for their own safety and fear of leaving loved ones behind. For some women this fear was related to a new sense of the uncontrollability of the illness which contradicted their earlier expectations of pregnancy. Bella's account illustrates this. Bella had regarded pregnancy as a '*very natural thing*' and had considered herself to be in '*exceptional health*'. She suffered eclampsia in her first pregnancy. Bella experienced a particularly severe consequence of pre-eclampsia in that she went on, post the birth, to have two eclamptic fits and it was thought she would suffer brain and kidney damage. She was in intensive care for three days. Pre-eclampsia shattered her notion of pregnancy as being something one can safely enter. She had believed that the medical profession would be able to identify any serious problems. The nature of her experience, however, meant that there was no identifiable problem until the eclamptic fits occurred. Any sense of the controllability of pregnancy was lost. Her good health status did not prevent the illness and the routine surveillance had not predicted the serious complication of her pregnancy. She expressed her fear of suffering again from the disease and no longer wants any more children.

'It's only afterwards...you think...anything could go wrong, so in that way I was lucky to have a healthy child...It has certainly made me think twice about any more children...I think the medical side is the main reason for me not

wanting any more children'.

Some of the women had experienced other difficulties in previous pregnancies. These included having to be induced and experiencing premature labour. Nevertheless, it was only with pre-eclampsia that they came to redefine pregnancy as risky and something to be avoided. Factors which distinguished their experience of pre-eclampsia from their previous difficulties included level of severity, a sense of its uncontrollability and sometimes its lack of visibility to medical surveillance. For example, Kari had thought she '*knew what to expect*' because of her previous pregnancy. Her first son had to be induced rather than naturally delivered but it was when she experienced pre-eclampsia in her second pregnancy that the problems associated with pregnancy became risks to be avoided. The problems in her first pregnancy were not as serious or experienced as frightening as those in her second. Her daughter was born nine weeks premature.

'It was an experience I never want to encounter again. I feel lucky that I have a son and a daughter and I will not be having any more children.'

Pat too had experienced difficulties with her previous three pregnancies but it was only with pre-eclampsia in her fourth and her knowledge that both her baby and she might have died through it that she now, two years after suffering pre-eclampsia, considers pregnancy as something to fear and something to be avoided. She described pregnancy as something that is characterised by lots of positive things but things which can suddenly be taken away.

'...looking forward to conceiving and showing you're happy about this pregnancy and this baby growing inside you and then suddenly it can all be taken away in a flash...you know I thought maybe like mothers can die in childbirth a few years back but not in this day and age. You think everything is

going to be straightforward...but that's just not the case...we will not risk it again.'

For some women it was only with a reoccurrence of pre-eclampsia that avoidance became a strategy. A reoccurrence of pre-eclampsia was sometimes the factor that led women to avoid pregnancy. Two factors characterised the experiences of those who chose to become pregnant after experiencing pre-eclampsia. Firstly, a perception that the earlier illness had been well controlled with a good outcome, defined in terms of the well being of mother and baby. This is illustrated in the account of Linda who suffered pre-eclampsia in both of her pregnancies.

'Well we felt because we had been through it and [daughter] came on so well. You know after the first few rocky weeks she just absolutely thrived. She came on so well...she is no different to any other five year old...I didn't want to stop at one baby, so we decided we would take a chance. Hopefully, even if I did have pre-eclampsia, if the baby was, you have to be a little... about it as well, even if she was born prematurely...otherwise you would never do it again would you...we won't take another chance...we will call it a day. If anything happens to the baby, if anything happens to me, they would have no one...but we have taken the decision that we wouldn't have anymore.'

A second factor that characterised the experiences of those who chose to become pregnant again was a belief that pre-eclampsia could not occur again. This is illustrated below.

'I went to the doctor and said I was thinking about another pregnancy...he said [he] didn't think it would happen again [that] it doesn't usually, it usually happens if you have a history of pre-eclampsia in the family which you have not. She went through all the risk criteria and basically [said] you have one already so it won't happen again...If we had realized it could have happened again I don't think we would have had [son] after the first time. I don't think I would have had him...it was only afterwards I felt [that] I don't want it happening again'.
(Ellen)

Several other women chose to experience a further pregnancy after pre-eclampsia. Pregnancy for such women was still seen as a risk, but one which could be taken because of a belief that the risk could be controlled and managed. Some women relied upon the efficiency of medical surveillance as long as they submitted themselves to it. Others believed in the controllability of risk through developing medical expertise about pre-eclampsia themselves. Some women drew upon this developing knowledge, and others upon knowledge based upon their own interpretation of the causes of pre-eclampsia, to attempt to control for risk by manipulating their life styles in various ways.

Pregnancy as Risky: Safety in Medical Surveillance

For some women, pregnancy became considered as something that was risky, but a risk which could be controlled through submitting to necessary medical supervision and intervention. All women who entered a subsequent pregnancy were more closely monitored in terms of how often they saw the midwife and consultant and how many scans and various other tests they underwent. Women who were considering another pregnancy took comfort and confidence in the surveillance that would be provided for them in possible future pregnancies.

'Although I am anxious about a future pregnancy, my husband and I feel it is worth proceeding. I visited my consultant who assured me...that I could have more frequent antenatal appointments.'

(Julie)

Another illustration of mitigating risk by submitting to medical expertise is found in Sharon's account. She gave birth to a daughter three months premature because of pre-

eclampsia. She had mixed feelings about having more children. Her worry, emerging from the knowledge that she is at risk of developing the disease in future pregnancies, is mitigated by her awareness of the availability of increased supervision.

'I know there is a chance that I could have the same problems again but I also know that my GP will keep an extra eye on me next time'

The way in which women came to centralise risk in their pregnancy expectations but deal with that risk through seeking medical control over it, can also be seen in the accounts of women who actually entered into a further pregnancy. For example, Linda wondered whether she had made things worse by, during her first pregnancy, not submitting to medical authority. Her second became characterised by such submission. In her first she did not see the purpose of hospital stays. She describes herself as '*resigning*' to such surveillance and intervention in her second after coming to understand the dangers of the disease.

'The second time round I knew about it and I was happy to do whatever I was told to do'

Regarding themselves as being safe if they submitted to medical surveillance is also revealed in their reflections on the care received during subsequent pregnancies. The common theme is that 'good' care becomes comparable to high levels of surveillance. Amanda, for example, wrote:

'I saw my midwife when I was four weeks and three days pregnant and was put onto low dose aspirin. I took these until thirty-four weeks. All through the pregnancy my care was excellent. I never went longer than two weeks without seeing anyone, usually the community midwife one week, the hospital consultant the next. I had regular scans to check the baby was growing okay...'

Her account also illustrates the way in which this submission is considered necessary, not just on the basis of clinical medical surveillance but on the basis of supporting women psychologically as they experience what they now consider is a risky pregnancy. Though initially adamant that she would never have more children, Amanda was thrilled at finding herself pregnant. However, her sense of safety and reassurance during her second pregnancy depended upon the medical surveillance of her condition. Increased monitoring reassured her that the risk was being 'watched' but her fear would occasionally emerge. The midwife became important to her during these times.

'Several times I got myself into a bit of lather, convinced it was all happening again and each time I phoned my midwife and she would be with me within a hour, never complaining about paranoid me, just ready to reassure me'

Defining pregnancy as risky led some women to reconsider their ideas on hospitalised births. Two examples demonstrate this. Mag's had previously considered a home birth as 'romantic' and had wanted such an experience. Entering her second pregnancy after experiencing pre-eclampsia in the first, she had no intention of having a natural birth, outside or inside a hospital. A hospital birth with direct intervention was the only option.

'I do not want the risk of anything else going wrong ...I want to sort out the date and get him or her out'

In their early conceptions and expectations of pregnancy and childbirth, many of the women had marginalised the role of medical surveillance and intervention. The consequence of pre-eclampsia was a change in their attitude towards this. Pregnancy was now risky. However, whereas for some this led to an avoidance of pregnancy, for others it led to a belief that submission to such surveillance was of central importance in defining their future pregnancy. The women seemed to have embraced the medical model's notion

of childbirth which centralises the concept of potential risk i.e. a birth is only normal in hindsight. The significance of this, I will discuss in the next chapter. In considering their changed perceptions of pregnancy, however, a third response is evident. Some women sought to control the perceived risks of their pregnancy through a process of self management.

Pregnancy as Risky: Self Management

So far we have seen how women who came to redefine pregnancy as risky responded to that position either by avoiding pregnancy or through a willingness to submit to medical monitoring. Such surveillance provided them with the confidence to ‘take a chance’ with another pregnancy. A third response to risk is here given separate consideration though in the lived experiences of women it was often intertwined with the previous response. This reaction was expressed in the accounts of those who coped with risk through in some way attempting to take control of it themselves. They did so by attempting to monitor and reduce risk. One way was through lifestyle changes. Chapters Four and Five began to identify the ways in which expectations of pregnancy and experiences of pre-eclampsia were in some way linked to a latent notion of risk, this risk sometimes being considered as something that is controllable through lifestyle, for example. Things isolated as risky included working, going on holiday, not eating correctly, becoming stressed and carrying heavy objects. One such consequence was a subsequent feeling of guilt when the risk was not successfully mitigated. This notion emerges again in some women’s reflections on how their perception of pregnancy had changed. Whilst this is seen most clearly in the accounts of those women who entered a further pregnancy, it is also visible amongst those who at the time of the research were contemplating the possibility of further children. An illustration of the need to reduce the risk through lifestyle changes is shown in Terri’s

reflections.

'I have lost six and a half stone and I will lose another couple, just to basically help the chances, although weight has nothing to do with it...'

And Cerri's:

'I learnt from my first pregnancy that you don't go out to work, you don't rush around the house. You don't push yourself. You keep yourself at a steady pace and what doesn't get done, well tough.'

Another aspect of self management, in an attempt to control or reduce the risk of pregnancy, involved developing expertise about pre-eclampsia. This expertise involved a medically defined understanding of the pre-eclampsia, its detection and means of control. Women seeking such information accessed it on the internet, through books and through support groups like Action on Pre-eclampsia. This allowed some to develop a sense of control. Thinking about the possibility of having another baby, and already in possession of medical knowledge, Fran explained:

'... That's why I contacted APEC and I do think it's important...I actually needed the knowledge. I needed to know everything, to reassure me that I had not done anything wrong and that also if I do ever get through another pregnancy that I know all the facts...and I (would) be more in control. I can say well this is what I have had before and you know this is what I want; you know to keep an eye on it I suppose.'

Most women wanted to know about pre-eclampsia. Earlier chapters showed the degree of self-confessed ignorance that existed about the illness. That lack of knowledge was to be challenged by women who considered it a factor in affecting their experience of pre-eclampsia. Post pre-eclampsia, they sought to arm themselves with the knowledge that they had so often lacked. Lorraine searched for information about pre-eclampsia after she had to

have an emergency caesarean at thirty-six weeks because of the illness.

'...because I wanted to find out more about it. I wanted to know mainly because I want to have another baby and just try to understand what had happened. I didn't have much information at all beforehand. I had never really heard of it beforehand.'

This developing expertise then was sought especially by those who wanted more children and it changed their subsequent experience. All women reported a 'better' experience which became revealed in a feeling of being more in control, this control sometimes presenting a challenge to the expertise and power of the professionals. This is seen most clearly in Brenda's and Linda's accounts.

After a first experience of pre-eclampsia, Brenda had concluded that hospital was the safest place to control the risk associated with her second pregnancy and birth. However, she '*...no longer trusted*' the professionals after believing that her baby should have been delivered earlier than it was. From this experience she was willing to challenge them on the basis of her developed understanding.

'I knew what to ask then as well. I knew what the questions were. I knew what it meant if I had a plus of protein in my urine. I didn't know what it meant the first time...[in the second pregnancy]...I wouldn't have accepted what they'd told me. You know 'ok it's only a trace'. I wouldn't have stood for that. I also know for a fact a couple of times going and not having my urine checked...I remember going down to the doctors. I didn't have a sample bottle. I remember the nurse saying to me, do you have a sample. I said, no I do not and she said well make sure you bring it next time. At that time I thought oh well, it's fine...and that stuck in my mind...but yes the second time around I made sure it was tested because I knew.'

Diane experienced pre-eclampsia in all three of her pregnancies. She considered her second and third experience to be 'better' because she was more aware of it and this

awareness enabled her to take some control.

'I mean it was a lot better the second time and the third time I mean I actually contacted the pre-eclampsia society and read much more about it, so I was much more aware of what might happen, I think you are much more clued into it'

Diane's developing expertise gave her the confidence to become greatly involved in the monitoring of her own condition through having urine sticks to test for proteinuria and taking her own blood pressure.

'I probably also knew a lot more and felt much more in control and I did things like if my blood pressure went up I would take a twenty four hour urine test...I would take it right away to clinic, that saved a bit of time being admitted...my main aim was to stay out of hospital (for as long as possible) and I did...'

Women's medical expertise developed both through the information they accessed and through the experiential knowledge that they all had. Suzanne, for example, described how she had developed an expertise based on her embodied previous experience and subsequent reading which enabled her to take some control and to be more assertive in asking about the nature of medical surveillance.

'They were telling me things and I was saying but that's not right, so I was actually telling them...I would go into the unit and have my blood pressure measured and I would watch them, I would be watching for every reaction...I would be like what's the number and they would say one hundred and five and I would say so when am I going downstairs...what's the reading of the protein in the urine, well's there's a little bit of protein, well what's the reading, is it one, two or three plusses...'

Women's experience of pre-eclampsia led to a revision of their ideas and assumptions

regarding pregnancy. It would be too simplistic to characterise this shift in terms of a movement from normalisation to medicalisation since, as previously seen, normalised concepts of birth at the level of individual women emerge partly through some kind of engagement with risk. Medicalised notions are partially integrated into those early images. However, submission to medical surveillance and intervention and self control through monitoring the risk of pregnancy suggests a more overt conformity to medicalised notions of pregnancy where risk is dominant. And yet despite such conformity, aspects of the medical model are implicitly challenged by the women's assertion. This was revealed initially in Chapter Five. It is considered further now through an exploration of women's interpretations of and desires for 'good care' which is seen as equating to more than just crude mortality and morbidity criteria.

What Women Want

Women were asked to reflect upon any improvements they felt were needed in the care of those experiencing pre-eclampsia. Their ideas locate the need for improvements from the stage of early pregnancy through to the post illness period. They include a range of issues ranging from improved information output and sharing, through to issues of emotional and social support. The majority of women had many thoughts on these which raise some questions for feminist analyses which promote a simple move away from surveillance insofar as many of their suggestions involve a move towards increasing medicalisation in the name of safety. Whilst it would be easy to marginalise these ideas for fear of reversing the apparent liberation of childbirth from medical control, I would argue that they clearly demonstrate the need to respond to the reality of pregnancy complications in a manner that does not simply locate them within a supposed disempowering context of obstetrical dominance. The women reveal the need for emotional support, sensitivity and

empowerment *within* a context of necessary intervention. Their ideas on improvements can be grouped into two categories: informing and supporting.

Informing

A consistent theme emerging from women's accounts is the experienced restrictions on information concerning pre-eclampsia, from the stage of early pregnancy through to the post pre-eclampsia period. It is not surprising therefore, when asked about possible improvements, that this issue was central.

'They could have told me about it beforehand. When I went for my booking in appointment somebody should have given me a leaflet. Then when you come down for your antenatal and you are going to come and offer your arm and your little pot of wee, there is some information about it...a leaflet that says if you feel dizzy or you are not peeing often, have a pain that won't go away...really bluntly put. I am fairly confident that in those three days when I was thinking that I've not peed as much as I should, I would have been thinking I wonder if this is a sign of pre-eclampsia and I would have gone to a GP.'
(Anne)

'If you go on to have a normal pregnancy and a normal birth, its fine. But nobody told you that things might not go according to plan and I think for a start your [parent craft] classes don't start until about thirty-five weeks. If you deliver [then] you are probably going to be alright...they're not going to go into the problems. I don't think you are given enough information.'
(Brenda)

All of the women wanted information available during the early pregnancy period, although some reflected upon the problem of producing anxiety in women and the fact of women marginalising such information.

'There should be more of it. And it should be more direct as well. I do feel that perhaps they don't want to scare people...it does happen to the minority rather than the majority.. But definitely if I had my time again I would have liked to have known more about it...'

(Cerri)

The women had various ideas on improving the information given to pregnant women including making the commonality of pre-eclampsia known. For example, Ellen wanted written information early on in the pregnancy that explicitly stated that *'...this could happen to you'*. Some suggested that information should identify the actual symptoms of pre-eclampsia more clearly. Those who had suffered the HELLP syndrome as a serious complication of pre-eclampsia spoke particularly of the lack of available information available concerning it and the need for that knowledge to be made more easily available to all women.

As well as written information, there were suggestions on other ways to supply more adequate information. For example Pat thought that women could watch a video of somebody *'...who has been through it or somebody who is suffering pre-eclampsia to see what some of the symptoms can be'*. Cerri believed that all surgeries should access and supply information packs from the charity Action on Pre-eclampsia.

As well as the need for more detailed information being provided to all during the early stages of pregnancy, there was an identified need for improvements in information circulated during and post pre-eclampsia.

'I think if someone had sat down and explained what I had gone through. If somebody had said, yes this is what happened to you and this is why...'

(Sandra)

This was considered particularly important in the context of self confessed

marginalisation of information concerning problems. Whilst Brenda confessed that she probably would not have taken on board information about it in early pregnancy, there was a need to make sure that women had understood what had happened to them individually.

'I should have been told and made aware of what happened. I was given a chat about what pre-eclampsia was by a midwife but not in the way that it affected me, but generally what it was.'

Supporting

Few women were happy with the level of social and emotional support received from health care professionals. Chapter Five showed how the majority were happy with their physical care but defined good care in a much more holistic way. The accounts suggest that women felt that their specific needs as women with pre-eclampsia, many with babies in neonatal units were not recognised and responded to. In sharing their thoughts on improving the care, the issue of support and what that would actually amount to on a practical level emerged. This included ensuring that women were made aware of support groups that would be able to offer them emotional support both in the short and long term.

'They should have said there is this society called APEC and this is what they do...you want to contact them all. I think all I feel I was left with was an acute illness with people struggling to manage it and then finally I went home. I was never given any written information on it.'
(Fran)

Having someone to talk to, be it a health professional or someone from a voluntary support group was mentioned by many women. The issue of having babies in special care, a common aftermath of pre-eclampsia in the mother due to necessary early delivery, was isolated by many women. Linda felt that women with babies in special care simply needed

someone to 'pop in and have a chat with you...even if it were once a week just to say how are you'. Irene felt that the needs of the mothers themselves were marginalised.

'...they seem to forget that mothers who have babies in the neonatal unit need support as well...we are just forgotten...the babies are being looked after and you are on your own. If you had somebody to follow you up, to make sure you are fine and that everything is alright with you, I think that would be nice'

The sensitivity of care practice was remarked upon by several women. They felt it insensitive to place such women in rooms with other mothers who have their babies with them.

'...some way of dealing with you instead of sticking you in a corner in a ward that has already got babies...I think it helps if you can be somewhere, or near where your baby is. There are people around you going through the same thing, rather than people who have had a normal baby, come in one day and out the next or whatever...and everyone congratulating them and you have to walk past...it just brings home to you that you haven't got your baby'.

I have argued previously how women's experience of pre-eclampsia cannot be understood through a notion of their being isolated patients but rather through one which includes a recognition of the relational aspects of the experience. That is one which locates women as mothers, daughters and wives for example and how these social networks impact upon and are shaped through the illness experience. The significance of this is confirmed in women's suggestions regarding improvements in that many isolated the need for support for their kin.

*'I feel as though there should be information and help groups for the fathers. I don't think anybody realises what they go through'.
(Pat)*

'I think it affects your relationship with your partner to start with, because he felt it was his fault that I got it because [of] not knowing what caused it...He was worried about me. Maybe there should be some support for your partner especially if you have other children and he doesn't know if I am coming home or not. It must be just as frightening for him not knowing what [is] going to happen.'
(Sandra)

A general need for individual emotional support and sensitivity is revealed in most accounts, concerns most easily marginalised when the concern is primarily with mortality and morbidity. The 'pregnant patient' notion is most easily enforced when a pregnancy fails to fulfil criteria of normality. However, what the above consideration of their wants show is that women faced with serious complications do not cease to desire their holistic needs recognised and promoted.

Summary

This chapter completes the presentation of the data. Chapter Four identified women's early ideas and expectations regarding pregnancy and their experience of it. In that chapter I suggested that underpinning their expectations was a process whereby women had engaged at some level with ideas of risk in pregnancy. This led me to problematise any conclusion about understanding women's early expectations in terms of accommodation to the medical or natural childbirth model. Rather, a more complex process was occurring.

Chapter Five began by considering the continual normalisation of women's symptoms and I explained this partly in terms of their early conclusions regarding the risk free status of their pregnancy. Their subjective concerns at this time began to reveal the way in which their experience was beyond that of a purely individual physical event. Rather, they had

wider subjective concerns regarding themselves and their significant others. With regard to the former, it was shown how whilst the overwhelming majority were happy with their physical care, they conceptualised their health care needs in wider ways, encompassing emotional and social support. With regards to the latter, their concern with their significant others and the way in which that showed the relational nature of the experience was testified further in the very accounts of a small sample of these significant others. This was the focus of Chapter Six.

This final data chapter began by revealing the different emotional consequences of pre-eclampsia during what I have called the post pre-eclampsia period, the time beginning when women had been discharged from hospital. The women also spoke or wrote about how they felt at the time of the research. For some this was weeks after the illness, for others, years. Feelings of guilt and 'being cheated' could be understood in terms of their earlier expectations which had not been shattered. In this chapter I have suggested that the changed perceptions of pregnancy, which basically centralise risk, were responded to in different ways. These multiple strategies were those of avoidance of future pregnancies, to attempt to control risk by submitting to medical authority and to control risk through self-management. Risk, sometimes manifest, at other times latent, has nevertheless been an emergent theme throughout the data analysis and I will show in the next chapter how this illustrates the problem of the existing feminist challenge and how a developed critique of medicalised childbirth must embrace an understanding of risk as a medical reality with regards to pregnancies and risk as constructed by childbearing women.

In considering the ideas women had on improving the care of those with pre-eclampsia, what is noticeable is the concern with wider forms of care than that which only contributes to their physical morbidity. In considering their ideas on improvements, this has again been made evident and demonstrates that whilst such complications may be defined narrowly

within the medical model, the lived experiences of women locates them within a similar holistic discourse within which only normal pregnancies are considered as legitimately belonging. Their voices therefore contest both medical and natural childbirth models as these relate to problematic pregnancies.

The next chapter presents my discussion of the main findings. Primarily, my intention is to show the way in which such findings present real challenges to some of the assumptions underpinning the feminist critique of medicalised childbirth and the alternatives which have been promoted.

Chapter Eight

Reconsidering Pregnancy, Normality and Risk

The previous four chapters have presented an analysis of the primary data. The findings have shown how women in the sample had initially constructed their pregnancies as normal. Though this normalisation was sustained despite developing symptoms, the transition to abnormality for which they were, by and large, unprepared was completed through the increasing visibility of pre-eclampsia to the women and doctors. The previous data chapter also revealed how women's perceptions of pregnancy were transformed through their experience of pre-eclampsia; from a notion of pregnancy as essentially normal, to a situation where pregnancy is defined as essentially risky. This final analytical chapter is concerned principally with discussing the relevance of these findings for the existing feminist theorisation on medicalised childbirth and offers suggestions regarding the way in which it might be developed.

The chapter has four sections. Firstly, drawing upon the empirical literature on problematic pregnancies reviewed in Chapter Two, I explore its significance in relation to my own findings. There is much that echoes previous findings and endorses the points authors have made. Fundamentally, however, I suggest that the findings from this study and the earlier empirical contributions support the central argument of this thesis: the need to develop a framework to challenge medical dominance over pregnancy but which encompasses, rather than excludes, women's experiences of complications.

Secondly, an issue apparent in some of the empirical literature considered on problematic pregnancies and a more dominant theme in my own findings is that of risk. This chapter will review the way in which risk was manifested in the accounts of the women in my sample to show the importance of integrating an analysis of risk in any developed framework.

Section three of this chapter will suggest the usefulness of the postmodernist perspective in understanding the marginalisation of risk in the classic feminist framework and the associated neglect of an analysis of problematic pregnancies. The significance of the expression of risk amongst women in revealing the limitations of the existing framework will be considered in relation to postmodernist ideas regarding the constraints of binary thinking.

In section four it will be argued that an alternative and more encompassing theoretical position might start to be developed by building on the postmodernist critique of binary thinking and integrating a consideration of risk, aided through existing insights available within the sociology of risk.

Pre-eclampsia and the Terrain of Problematic Pregnancies

The obvious point which unites this empirical work on pregnancy complications is a shared focus upon experiences of pregnancy and childbirth which are generally overlooked in the classic feminist critique of medicalisation. The findings from this study tell of one such type of marginalised experience, that of a pregnancy complicated by pre-eclampsia. Two of the women in my sample lost their baby as a consequence of complications of pre-eclampsia. The

literature considered relating to pregnancy loss offers important insights to such experiences which, as Layne (1997) claims, tend to hit a wall of silence. Lovell (1993) suggests that when a woman experiences pregnancy loss various hospital processes can operate so that her role as 'mother' can be lost, as to can her role as 'patient'. She recommends the use of various 'rituals', formal and informal, to help overcome some of these problems. The account of Alex in this thesis, whose son died, does indeed show the positive consequences when hospitals empower parents to undergo various rituals upon the death of their babies. For example, Alex and his wife were encouraged to dress, cuddle and take pictures of their baby. It might also be suggested that Lovell's notion of rituals is important in describing processes whereby parents are empowered to build and sustain their identities as parents in the context of long term stays in neonatal care; for example, by participating as fully as possible in their babies care. This would be further confirmed through Reid *et al's* (1995) research which recommended active parent involvement in the care of babies in neonatal units. The research for this thesis shows a further context whereby the status as parent may be undermined. Some of the women in my sample experienced a period of time whereby their role as patient was sustained due to their illness, yet their role as 'mother' undermined, not because of the loss of a child and the organisational response to this, but rather because of the objectification of their babies in neonatal care which left some battling with their status as mothers.

This thesis has revealed the way in which women with pre-eclampsia changed their definition of the situation over time as they moved from an assumption of normality, sustained even in the presence of developing symptoms, through to a recognition of the abnormality of their pregnancy and lastly, into a definition of future pregnancies as risk. As reviewed earlier, Thomas, H. (2003) used the concept of 'pregnancy career' as way of understanding the experiences of women with chronic and emerging pregnancy related illness. In principle my

findings could perhaps be seen in terms of this concept. However, the main intention of my research was to understand the construction of pregnancy normality and abnormality in relation to medical and alternative childbirth models and to analyse this in relation to existing feminist theorisations of medicalisation.

It is Lawson and Rajaram's (1994) work on a specific pregnancy induced illness that shares the most points of direct comparison to that of my own. Gestational diabetes has key similarities to pre-eclampsia, as considered earlier in this thesis. Consequently, it is not surprising to find points of comparison between their empirical findings and those of my own research. For example, women in both studies reported a sense of guilt for the disorder, sought information about it from various sources, and struggled with the definition of themselves as 'ill' because of the often 'hidden' nature of the disorders. Fundamentally, both groups of women experienced a transformation in their pregnancies through the development of these illnesses. This transformation is revealed throughout this thesis's data chapters as they move from a position of assumed normality, to a struggle with but eventual acceptance of abnormality, and for some into a position of locating risk as a defining characteristic of future pregnancies. Lawson and Rajaram reveal this transformation within a singular pregnancy episode, or what, Thomas, H. (2003), would call 'pregnancy career'. The findings in this thesis, however, have revealed how it transforms, not only experiences of a specific pregnancy but also the expectations and subsequent experience of any that follow. The concept of 'transformed pregnancy careers' might, therefore, be of more potential usefulness.

The findings of this thesis have revealed the central place of risk for women and how they dealt with this in various ways, including trying to gain some control over it. Research on women's experiences of pregnancy who suffer from chronic illness already had begun to

tackle this issue in a somewhat different context and my own findings therefore echo some of the themes of this literature. The work on disability (Thomas, C. 1997; Lipson and Rogers, 2000) and that which wholly or in part considers chronic conditions (Corbin, 1987; Thomas, H. 2003, 2004) differs in that, unlike pre-eclampsia, the women involved had to deal with 'conditions' known about and prior to their pregnancies. For example, disabled women's experiences were shown to be affected in part by the particular nature of their disability and they were often overtly embraced within a risk discourse from the earliest stages of their pregnancies. The women in my sample did not have a disability and the data reveals how the overwhelming majority were, for a considerable time, able to distance themselves from the concept of risk, though as shown in this thesis, this was apparent only after an initial engagement with risk. However, this thesis has shown how many of the women who entered subsequent pregnancies either chose or had their pregnancies defined overtly through a risk concept. Corbin's (1987) identification of 'protective governing', described in Chapter Two, is therefore a useful concept in understanding some of the processes that women in my study who entered subsequent pregnancies worked through in order to try to minimise the risk and consequences of pre-eclampsia. Whilst Thomas, C. (1997) argued that the concept of being at risk was disabling to the women in her sample in many ways, some of my respondents were enabled by 'being at risk' to display strategies of resistance. Some, for example, were more inclined to seek information concerning pre-eclampsia, to challenge medical responses to them and to demand certain forms of supervision and intervention.

In Chapter Two I argued that the existing work on pregnancy complications provides a foundation for asking fundamental questions about the sufficiency of the classic feminist critique. In this chapter I have shown how some of the themes evident in the various contributions are endorsed by my own findings. However, these findings have also revealed a

more complex engagement with medicalisation and normalisation revealed through my analysis of risk as it emerged from the data. Understanding experiences of problematic pregnancy requires a consideration of risk as expressed and experienced by women themselves. This is the concern of the next section.

The Experience of Risk in Pre-eclampsia

An emergent theme throughout the data analysis was that of risk. This section of the chapter is concerned with reviewing the way in which risk emerged in the research findings and its centrality in the thinking of women both in their experience of pre-eclampsia at the time and in future considerations of pregnancy. Women's engagement with the possible risks of pregnancy was evident at four points. Firstly, it was visible in the development of their early pregnancy expectations. Secondly, the impact of such engagement was shown in their normalisation of problematic symptoms. Thirdly, their emotional reactions to pre-eclampsia, in particular their feelings of guilt, reveal the way risk was attended to amongst the women and lastly, the importance of risk in women's experience of pre-eclampsia is evident in their revised perceptions of childbearing. The way in which the expression of risk in the women's accounts problematises any challenge to medicalised childbirth based upon the promotion of alternative models such as natural childbirth, will be considered further on in this chapter.

The first point at which risk became evident in women's pregnancy experiences was in their early expectations of pregnancy. The data revealed that women had constructed their ideas about pregnancy through drawing upon certain medical constructions of risk rooted in known epidemiological patterns made available to them. The risk of Down syndrome for those

aged over thirty-five was the most commonly known. The findings showed how the level and nature of the information given and accessed by women was important in understanding their perception and response to risk. However, it was also clear that the marginalisation of knowledge by women and the influence of friends and family were also processes of importance. Some women marginalised risk because of their previous perception of it, others because of fear and some incorporated medical surveillance into their conclusions by believing that any risk would be identified by the medical profession. The impact of significant others was also revealed in that in forming ideas about the reality of any risk to their pregnancy, women would be influenced by the experiences of others known to them. Thus, some women expected their pregnancies to be normal because they were unaware of any relative who had experienced a pregnancy complication. It is from these resources and through such variable processes that they came to conclusions regarding the expected normality of their pregnancy. Analysing women's expectations of pregnancy and the conditions within which to make sense of them thus made clear that women had engaged with risk, attended to it and then largely discounted it.

Whilst risk was evident in these ways, it can by no means be argued that women unproblematically assumed the medical concept of risk. Rather than 'swallowing' a medical book, women's concepts of pregnancy risk seemed to have emerged from having come across certain ideas of possible risks. These ideas were then mediated through the influence of others, access to information and previous experience. Can we conclude that we can make sense of their early expectations and experiences in terms of a partial accommodation to both natural and medical models of childbirth? Could it be claimed that women have simply taken on board elements of both models? I suggest the answer to both of these questions is no. Rather, women arrived at an expectation of normality through a process of engaging in risk, risk being

the premise upon which the medical model gains its legitimacy. In other words, the medical model, though not assumed in an unproblematic way, forms the basis of women's expectations.

The second point at which women's engagement with risk was evident was where symptoms began to emerge suggestive of the illness. An important theme identified was the way in which they would often redefine these symptoms as normal. Processes which influenced this redefinition of symptoms included previous experience of complications, a subjective experience of 'feeling well' and other people, including in some cases the medical profession, normalising the physical changes. I suggested that these processes received greater legitimisation because of women's initial engagement with risk that had led them to assume the normality of their pregnancy.

Risk emerged at a third point, namely in my exploration of their psychological reactions during and after pre-eclampsia. The transformation of their pregnancies into those defined as deviations from normality was not achieved simply through the existence of certain physical processes. As shown above, many women initially normalised symptoms. The increasing visibility of pre-eclampsia through, for example, a sense of feeling unwell and medical responses to symptoms, eventually led to the completed transformation of their pregnancies. At this point, women's subjective responses included fear, shock and guilt. It was suggested that the latter response was ultimately related to their earlier consideration and then marginalisation of risk. For example, some women reflected upon previous activities and the degree to which these may have increased their risk of suffering pre-eclampsia. Others were surprised at being ill because of engaging in various activities, like eating well and exercising, which they assumed would reduce their risk of pregnancy. In the medical model risk is largely

individualised; it is considered that people can control risks through life-style strategies and general self-monitoring. The way in which women responded to pre-eclampsia through a reflection upon what they did or did not do makes evident the way in which they, at some level, engaged with this medical construction of risk.

Fourthly, the significance of women's engagement with risk was particularly evident in the way women came to view and respond to actual or real subsequent pregnancies by centralising risk. This study has shown how this re-engagement with risk took three forms; the latter two described here were often intertwined. Firstly, some women chose to simply avoid the risk by determining never to get pregnant again. Other women, however, although perceiving pregnancy as risky, believed that it was possible to control the potential of adverse pregnancy outcomes. For some, this was manageable through submission to medical surveillance and supervision. The third response to conceptualising pregnancy as risky was to believe in its controllability but through processes of self management. One way this was attempted was through life style changes like losing weight.

The above overview clearly shows the importance of risk in the experiences of women who participated in the study. Whilst centralised after pre-eclampsia, risk was always evident in women's earlier conceptions and expectations of pregnancy. Corbin (1987), considered in Chapter Two and the previous section of this chapter, had revealed the importance of risk and the response to it in chronically ill women's experiences of pregnancy. This thesis has demonstrated its significance to women without chronic illness and who entered pregnancy with apparently every reason to assume its normality. Given this, the need for an analysis of risk as constructed through pregnancy and expressed and experienced by women, is evident. At the time of Corbin's contribution the sociology of risk was in its infancy and therefore she

would have been unable to incorporate any of the now available frameworks for analysing risk. However, it is surprising that literature pertaining to the sociology of risk has, so far, made little contribution to such an analysis in relation to pregnancy and childbirth. Such analytical poverty is also evident within feminist theorisations regarding pregnancy. Since risk has been considered as central to the medical model's construction of pregnancy, risk has primarily been considered in terms of its ideological role in justifying medical control rather than its complex and variable expression amongst women themselves. The next section considers the value of postmodernist insights in comprehending the reason for this neglect and points to a possible way by which the feminist framework can incorporate an analysis of risk in women's experiences of pregnancy and childbirth.

Postmodernist Feminism and Risk: Challenging the Existing Feminist Critique

It has been suggested in this thesis that the feminist challenge to medicalised childbirth is premised upon binary thinking. This argument is derived from postmodernist critiques of modernist feminism. A key question is what is the relationship between notions of risk as evidenced in women's accounts and binary thinking as it underpins many existing feminist challenges? In what way does risk, as expressed through the reality of pre-eclampsia, and risk as constructed by the women, present a challenge to many existing feminist contributions on medicalised childbirth premised on binary thinking? This section of the chapter will attempt to answer such questions. It begins by reviewing the postmodernist challenge in light of this study's findings. I do not claim to be undertaking a strictly postmodernist feminist analysis in relation to my thesis, rather I consider some of the ideas as they have emerged from their challenge to modernist feminism as useful in making sense of my own research findings and

in beginning to develop a critique of medicalised childbirth which is not premised upon the marginalisation of abnormal pregnancies. The argument of Annandale and Clarke (1996) is drawn upon in an attempt to theorise the significance of risk within the accounts of women who participated in my research. In doing this, I aim to show how the unsatisfactory silence of existing feminist writers on problematic pregnancies and the reality of risk that these pregnancies demonstrate, might be overcome.

De-Beauvoir (1974) argued that women were always constituted socially and linguistically as the 'second sex'; woman has always been defined as 'Other' to man and, thereby, inferior. In an attempt to contest this, radical feminists in particular, sought to emphasise and celebrate the essential nature, the fundamental difference, of woman compared with man. For postmodernist feminists, however, to do this is to still engage with the linguistic categories of what is claimed to be a phallogentric symbolic order. To engage with such categories is to recreate them. Cixous (1971) claimed that masculine language is constructed through binaries; the foundation of these, as also identified by Beauvoir, is the man/woman distinction whereby the former is accorded the power to define the nature of the latter. Therefore, the concern should be to deconstruct, rather than reproduce these binaries and to reveal the way in which they are indeed constructed through the dominance of the masculine. This process is described by Annandale as involving an understanding of how the dominant position in a particular binary (she uses the example of able bodied/disabled) is only made possible through contrast with the subordinate position. Therefore, 'able-bodiedness' is not opposite to but rather interdependent with 'disability' insofar as its meaning depends upon an understanding of the nature of 'disability' (1998, p.46). Once deconstruction is in place, heterogeneity can replace binary thinking. Finding the similarities between men and women can contribute to the breaking down of the distinction which is potentially liberating for women insofar as men's

defined superiority is dependent upon women's defined inferiority (Annandale and Clarke, 1996). Modernist feminists unwittingly accept the basic dualism inherent within the symbolic order and postmodernist feminists argue that this is what leads them inadvertently to collude with the very discursive order within which the feminine is considered inferior.

Such arguments form the basis of a postmodernist critique of feminist perspectives as they have been used to understand women's reproductive health experiences and can most clearly be seen in the work of Annandale and Clarke (1996). Annandale and Clarke begin their critique by arguing that within the sociology of health and illness, feminist theories are rarely explicitly revealed. The assumption is of a unitary and unproblematic body of feminist thinking. Indeed, the very fact that I was able in Chapter Two to refer to 'the' feminist critique of medicalised childbirth illustrates this lack of explicit differentiation within the literature on medicalised childbirth. According to Annandale and Clarke, whilst not often made explicit, feminist critiques are often grounded within radical feminist assumptions. This has meant that strategies have been developed, firstly, from the presumption of 'essential' gender differences, such as characterising the natural childbirth model, and secondly, from the assumption of technology *per se* as male control. Hence, 'new midwifery', for example, is defined by a marginalisation of technological interventions. Both of these express the dilemma of binary thinking as represented in many feminist challenges to medicalised childbirth. The former point, the assumption of essential gender differences, will firstly be considered in relation to my findings and it will become clear how the expression of risk in women's accounts makes visible this dilemma. The latter point, the promotion of 'new midwifery' as a challenge to the assumed inevitable relationship between medical technology and male control, is considered in the final chapter of this thesis.

As previously discussed in Chapter Two, essentialism universalises women's experiences and thereby is unable to embrace variations in women's lived experiences of pregnancy and birth. This is an identified problem, for example, with the natural childbirth model (Brooks and Lomax, 1999). The failure of the alternatives which emerge from an essentialist basis to embrace women's varied experiences has been shown with the sample of women who suffered pre-eclampsia in two particular ways. Firstly, the data illustrate how the women in the sample could only sustain a sense of their pregnancy as conforming to that promoted in the natural childbirth model (natural, normal and controllable) by marginalising the abnormal. The lived realities and consequences of this were identified and it was shown how some women defined developing symptoms of abnormality as aspects of a normal pregnancy process. This was especially the case when symptoms were experienced as exaggerations of normal changes like swelling and nausea. Normalisation only ceased when the illness became 'visible' through an increased sense of feeling unwell and medical concern being shown.

The marginalisation of abnormality did not, however, in my findings reflect a rejection of the medical model and its associated concepts of risk. Rather, the conclusion of the normality of their pregnancies emerged through a process whereby risk was, at some level, engaged with. Whilst sometimes this process seemed to involve what might be referred to as examples of 'lay paradigms', in that their notions of risk were situated within their own biography and bodily knowledge (no previous problems, for example, and 'being healthy'), as well as through their referral networks and cultural ideas of natural childbirth, ultimately these conclusions were situated within the framework of medical ideology. Clearly, however, the women engaged with risk in a much more complex manner than the feminist theorisation recognises.

The previous section has argued that, just as the marginalisation of abnormality did not reflect a rejection of the medical model; neither did it represent women's uncritical acceptance of the natural childbirth model. It was shown that their ideals of normality were variable, with some seemingly contesting central concepts of the natural childbirth model. Women's conceptions of pregnancy and the consequences of them for their experiences of pre-eclampsia reflected a complex process whereby both models were drawn upon but neither model totally embraced. Therefore, women's accommodation of the natural childbirth model was variable and sometimes contradictory and their subsequent embracement of risk was responded to in different ways with some presenting an implicit challenge to the medical model. Nevertheless, as discussed above, the drawing upon of these two models reflects the reality of binary thinking insofar as though their lived choices were multiple, the medical model was ultimately privileged. Whilst this did not represent a wholesale acceptance, it nonetheless was evidence of a 'leaning upon' the medical model and therefore the foundation for their conclusions regarding the normality of their pregnancies.

There is a second way in which the failure of alternatives based on essentialism, particularly natural childbirth, is evident in the accounts of women who suffered from pre-eclampsia and demonstrated particularly through the expression of risk in their accounts. During their illness, the power of the natural childbirth model to deliver care to meet their physical and wider needs was superseded by the intervention and surveillance characterising the medical model. After experiencing pre-eclampsia, many of the women assumed the medical model in variable ways by centralising more visibly the concept of risk and either avoiding or attempting to control it in ways including submission to professionals. When normality remains unfulfilled, women were left only with that model through which their experiences are expressed, understood and responded to: the medical model. This then placed

them totally within a medicalised context, the focus of which is on morbidity and mortality outcomes and an under-playing of women's wider needs. Abnormality is evident within the language and associated practices of the medical model and perhaps this explains the way in which women then focused more upon that model's central assumption, that of risk, in their subsequent pregnancies. It is in the case of problematic pregnancies, like pre-eclampsia, that the power of the medical model in ultimately defining and controlling women's childbearing experiences is made most visible. It is in these situations that I suggest we can see the way in which alternatives constructed in contrast are shown to be 'other to' the medical model and through this, sustaining its power.

Both the tendency of women to retain a sense of the normality of their pregnancies through marginalising abnormality and their more explicit consideration of risk in possible and actual subsequent pregnancies reflects the inability of the natural childbirth model to embrace the reality of such women's experiences given its fundamental premise of normality. The emergence of risk in women's accounts makes problematic feminist analyses which promote natural childbirth as an alternative in so far as such risk engagement reveals the subjection of the alternative model to the medical model. Conclusions of normality which may partly, though not unproblematically, reflect natural childbirth ideals, are arrived at through some consideration of risk, a central concept of the medical model. It is through the expression of risk that the limits of binary nature of the normal/abnormal, natural/medical construction becomes evident and the way in which the latter categories have the power to define the former. To present a challenge to medicalised childbirth from the premise of binary constructions, as the classic feminist critique does, is to reproduce the symbolic order within which women are defined as secondary and to present no opportunity for women, in relation to childbirth, to emerge from the constraints of such thinking. It is the binary thinking inherent

within feminist challenges that can easily lead to the promotion of an alternative like natural childbirth which has little defining power for women with serious pregnancy complications. It is the essentialist basis of the classic feminist challenge that constrains it within such thinking and results in a framework which begins with what *should* be the case rather than what *is* the case in terms of the reality of women's differing pregnancy and childbirth experiences. The evidence of women's complex engagement with risk and their different strategies to respond to it reveals the dilemma of this inadequate theorisation. It can be argued, therefore, that the postmodernist critique provides a 'place' to address problematic pregnancies by encouraging the development of a challenge which does not reside within the constraints of binary thinking and which begins with the lived experiences of women, including their variable and complex embracing of risk.

Postmodernism and the Sociology of Risk: Towards a Developed Feminist Critique?

What might this developed challenge look like? I do not claim to have constructed a fully developed framework but I am able to outline some theoretical considerations which might aid such a development. These considerations are not presented as a replacement to the existing framework. The feminist critique, outlined in Chapter Two, has undoubtedly contributed much. The detrimental impact of some maternity care practices has been revealed and the unnecessary generalisation of obstetrical intervention challenged. The wider social and political forces whereby such practices were developed and reproduced have also been illuminated through such contributions. Rather than an attempt to replace the challenge, therefore, these considerations are presented as a possible way forward whereby the challenge may be expanded in such a way that problematic pregnancies no longer need be marginalised

in order to sustain the critique.

Firstly, there is a need to recognise the legitimacy of the postmodernist challenge to modernist feminist theorisations. There is a need to develop the feminist critique of medicalised childbirth by moving beyond the binary thinking and essentialism which has so far constrained it. The essentialist basis of the framework has meant that women's varied experiences are not fully incorporated and we are left with a challenge which consists only of normative claims rather than a grounded consideration of the reality of women's childbearing experiences. The thesis has revealed, not only pregnancy experiences previously marginalised but importantly, the diversity and complexity of such experiences. For example, it has shown how in constructing the normality of their pregnancy and in reconstructing their pregnancy expectations after pre-eclampsia, women drew upon the medical model in differing ways. Postmodernism invites us to reveal and recognise the significance of such varied experiences and the limitations of any framework which is not grounded in the reality of diversity.

The postmodernist challenge also encourages us to see the constraints of binary thinking. A developed feminist challenge to medicalised childbirth thus needs to begin with a refusal to reproduce the normal/abnormal divide. Instead, any feminist analysis would need to start by fully encompassing the possibility of abnormality, therefore liberating it from the exclusive power of obstetrics. When an attempt is made to move beyond the binaries and therefore away from an exclusive focus on normality, an analysis of risk becomes more possible. A developed feminist critique must involve, therefore, a consideration of the reality of risk through empirical research. The potential usefulness of insights from the sociology of risk then becomes more visible. For example, research could be conducted into how pregnant women's experiences and expressions of it are a product of social forces, such as those identified in the

socio-cultural and governmentality approaches. The potential value of such approaches is revealed through my own primary data. The socio-cultural approach suggests that risk knowledge is constructed through different, sometimes competing and contradictory, situations, experiences and groups. This thesis has demonstrated how the women's construction of their pregnancy as being risk free was understandable in terms of their drawing upon, not only expert knowledge, but also the knowledge of their peers and their own previous embodied experiences. Zadoroznyj's (2001) research, reflecting the socio-cultural approach, suggests that women engage in 'conscious risk assessment' (p.117) as they operate as consumers of maternity service. This is confirmed through my own findings. However, where she found that women's embodied experience of an unproblematic pregnancy decreased the emphasis upon risk, my research suggests that for some, an experience of a pregnancy defined by serious complications may lead to a centralising of risk and different ways of dealing with it. Women responded to the potential risk of future pregnancies by avoiding pregnancy or seeking to control for risk through submission to medical intervention or self management strategies.

An aspect of the governmentality approach, identified by Zinn, is the way in which different discourses construct risk. According to Nettleton (1995) the ideological basis of medicine has changed from that of the biomedical model towards a psycho-social model which encourages self regulation and monitoring and the avoidance of risk. This thesis has revealed the ways in which some women reflecting upon their illness, and or entering subsequent pregnancies, constructed their risks in a way suggestive of their power to self regulate and monitor it. Some, for example, experienced a sense of guilt at not maintaining a 'risk reducing' lifestyle and others believed they could control or reduce the future risk of pre-eclampsia through self regulation and monitoring. These findings and further research into

pregnancy and childbirth could therefore be usefully analysed through the perspectives available within the sociology of risk.

The complex and variable expression of risk in women's accounts problematises a feminist challenge which has an essentialist basis and is constrained by binary thinking. The consequential downplaying of the significance of risk results in a marginalisation of women whose pregnancies do not conform to expected normality. The feminist critique of medicalisation has contributed much to our understanding of the limitations of medical control over pregnancy and childbirth. This challenge must not be lost; it must be developed. It can be suggested that the only way to create a challenge in such a way that problematic pregnancies do not have to be marginalised in order that the critique be sustained, is to embrace the concept of risk within a feminist framework. This begins with recognition of the usefulness of postmodernist challenges to existing feminist critiques of medicalised childbirth and results in an analysis which is grounded in the diversity of women's pregnancy experiences and therefore the reality of their expressions and experiences of risk. Risk should be critically embraced, its use as a justification for unnecessary intervention and obstetrical dominance challenged. Equally, however, its marginalisation should be challenged in a manner beyond that of a token gesture. The challenge should inform a developed feminist critique and the care practices which it informs.

Summary

This chapter has moved from a consideration of my study's findings in relation to previous empirical literature on problematic pregnancy, to an attempt to identify the potential

usefulness of both the postmodern challenge and the sociology of risk in any developed feminist critique of medicalised childbirth. Primarily, it has suggested that the binary thinking upon which many existing feminist challenges and promoted alternatives to medicalised childbirth are based renders the actual experiences of women with serious pregnancy complications invisible. In this sense, the experiences of women with pre-eclampsia highlight the fundamental problems of trying to conceptualise the issue of medicalised childbirth and its challenge in terms of supposedly opposing models of childbirth. In the context of the research findings, such experiences suggest the legitimacy of the postmodernist informed theoretical critique of feminist analyses. It has therefore been suggested that a developed feminist challenge to medicalised childbirth needs to begin with an attempt to operate outside the constraints of binary thinking; this would have theoretical and empirical consequences. The latter involves an attempt to develop a concise sociological understanding of pregnant women's experience of risk. Existing empirical research on problematic pregnancies have already provided a foundation for this, by revealing these marginalised experiences which are often defined by a need to respond to and engage with risk. My thesis has attempted to comprehend their marginalisation in terms of the constraints of binary thinking which, with regards to pregnancy, involves constructing a challenge based on the dualism of normal/abnormal. Recognising the need to operate beyond such thinking is not necessarily the same as promoting a full-blown postmodernist critique of medicalised childbirth. Rather, it is to appreciate the value of postmodernist critiques of binary thinking in developing the challenge and expanding the critique through drawing upon existing understandings within the sociology of risk. Indeed, it has been argued that a developed challenge needs also to embrace the reality and construction of risk and this can be aided through a consideration of the insights provided by the sociology of risk.

Women with problematic pregnancies have, it seems, if not intentionally then by default, almost been relegated by some feminists, the natural childbirth movement and even, it could be argued, the midwifery profession, to the very medical model of care which has been justly criticised for its dis-empowering nature. This results in an absence of any theoretical - and largely any empirical - consideration of ways of improving the care of such women. The following and final chapter of this thesis considers further the implications of my analysis in relation to midwifery practice and the policy within which it is framed. It then summarises and draws out the implications of my findings further and considers the limitations and possible challenges to the research.

Chapter Nine

Practical Implications and Evaluation of Research

This thesis has explored the perceptions of a sample of women who had suffered pre-eclampsia. Using the accounts provided by thirty women who had experienced the illness, the thesis has aimed to present their own accounts of complicated pregnancies and the significance of these to them. The research has therefore shed light on the consequences of pre-eclampsia in terms of women's changing understandings and expectations of pregnancy. This final chapter has two purposes. Firstly, the theoretical concerns discussed in Chapter Eight are applied to a consideration of maternity policy and midwifery practice. In Chapter One, it was suggested that the apparent decline in critical feminist work on childbirth might be related to the assumption that with the change in policy established by *Changing Childbirth* (1993), maternity care had indeed become more woman-centred. In the first part of this final chapter, some of the results from my research are used to build upon some existing challenges to this conclusion. Suggestions for improved care for women experiencing pregnancy complications are then outlined.

The findings presented in this thesis pose both a theoretical and practical challenge to the previous corpus of work and I suggest that it is in these two challenges that the particular contribution of my research resides. A second intention of this chapter, therefore, is to evaluate the strengths and potential criticisms of the study. After addressing three potential challenges to the research design and interpretation of findings, the chapter summarises the overall contribution of the research and considers some steps that might be taken by subsequent researchers.

Problematic Pregnancies, Midwifery Practice and Maternity policy

It was identified earlier in this thesis how many feminist critiques are often implicitly grounded within radical feminist assumptions. The result of this is that strategies to contest medicalised childbirth have assumed essential gender differences and this can be seen expressed through the ideas of the natural childbirth model. It has been shown how this proves unsatisfactory and is most revealed in the case of women experiencing problematic pregnancies. However, the radical feminist influence on existing analyses has also meant that childbirth technology is considered as male control per se. This is made evident in 'new midwifery' which is defined by a downplaying of technological interventions and has been promoted as a challenge to the medicalised model of childbirth (for example, Oakley, 1984 and Kitzinger, 1988, considered in Chapter Two). Annandale and Clarke suggest that if the strategies associated with the 'new midwifery' are constructed simply through contrast with the strategies associated with obstetrics, then they do in effect '...attribute to it the power which it gives itself', (Annandale and Clarke, 1996, p.30). Midwifery's assumed inferiority becomes evident in cases of complicated pregnancies when the midwife's skills, strategies and knowledge become secondary to the skills, strategies and knowledge of the obstetrician. The implications of this binary thinking are apparent, not only in the report *Changing Childbirth* which was widely responded to at the time as progressive, but in the midwifery profession's own contemporary assertions of their role. Both will now be considered.

Changing Childbirth, the report of the Expert Maternity group published in 1993, was widely considered a radical departure from all previous maternity reports insofar as it claimed to promote a woman-centred approach to the organisation of maternity services. The language used throughout suggests an accommodation to the terminology of natural

childbirth though the extent to which this reflects progress towards a woman-centred system of maternity care has already been criticised (Brooks and Lomax, 1999). Nevertheless, for those who had been critical of a system of maternity care based upon a medicalised version of pregnancy and childbirth and who had argued for one which instead assumes such processes to be natural events, throughout which the needs of women are centralised, *Changing Childbirth* may well be considered as radical progress. Furthermore, the report's assertion that maternity care should make full use of midwifery skills suggests an endorsement of the primacy of the midwives role in uncomplicated pregnancies. Again, this may well be seen as a partial victory by those who have promoted the midwife as a defender of the 'naturalness' of pregnancy and birth against a male dominated obstetric profession (Oakley, 1993, 1995).

Changing Childbirth highlights the role of the midwife in uncomplicated pregnancies. The report's assertion of the role of the midwife primarily in uncomplicated pregnancies is illustrative of the way in which midwifery is constructed as 'other to' obstetrics and is thereby always limited in its potential to empower women (Annandale and Clarke, 1996). The medical model and the profession of obstetrics which is privileged by it are legitimated by the very existence of risky and complicated pregnancies which are considered its object. However, as shown in Chapter Seven, women themselves who suffer serious complications consider good care not just in terms of morbidity and mortality outcomes but in wider ways, care traditionally associated with the midwifery profession. Listening, caring and having the time to talk were all valued. Chapter Two noted how some had argued that midwives and obstetricians have different perspectives towards childbirth, enabling the former to be more able to engage in care defined in ways mentioned by the women in my research. The report's association of the profession, however, primarily with uncomplicated pregnancies denies the full potential of it in supporting and promoting the care required by women with serious complications.

Changing Childbirth, in its promotion of midwifery in normal pregnancies and apparent acquiescence to the natural childbirth model, is essentially couched within the binary thinking that defines most existing feminist critiques of medicalised childbirth. The result is a failure to fully engage with and meet the needs of women with pregnancy complications.

Midwifery continues to define itself primarily in relation to normal pregnancies and this makes evident the way in which binary thinking impacts upon the profession. This is seen in the Royal College of Midwives recent campaign for normal birth (Royal College of Midwives, 2005) whereby promoting normal birth practices reflects their assertion of it being central to the profession. Their 'Position Paper on Normal Birth' (2005) makes it very clear that 'midwives are expert professionals skilled in supporting and maximising normal birth...' This I argue is to be regretted. Whilst I agree with Kirkham (1986) that one role of midwifery is to defend the normality of pregnancy against a medical ideology which suggests otherwise, it is also surely the case, as she herself also argues that midwives '...are just as much present and needed with the abnormal' (p. 43). Insofar as the profession continues to align itself, however, primarily with normality, then attempts to challenge the nature of care dominated by the medical model by promoting midwifery care are of potential benefit only to those women whose pregnancies can be considered normal. My findings suggest, however, that woman with complications require and indeed seek the care ordinarily associated with midwifery. In Chapter Seven I showed how women defined improvements in their care in terms associated with the nature of care identified with midwifery. They considered their needs to be more than just physical. Psychological care and support were also important. Such findings make visible again the problem of binary thinking which pervades most feminist challenges to medicalised childbirth. This thinking leads to the construction of midwifery as oppositional to abnormal childbirth which remains the sphere of obstetrics. The result is the reproduction of the dominance of the

medical model, expressed through obstetrics, as women with pregnancy complications are located uncritically within that very model of care.

A report produced jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives considered ways of organising labour wards so as to provide for 'safer childbirth' (Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, 1999). This report also asserted the primary role of midwife as being in relation to normal childbirth. While it suggested that in more complex pregnancies, midwives work as partners with obstetricians, the actual nature of this partnership at the practical level is not made very clear. Research suggests that midwives are already constrained in their ideal practice by the very culture of the maternity services (Kirkham and Stapleton, 2004). In a context of serious complications it might be suggested that any suppression of their role through the assumed dominance of obstetrical skills, would be heightened. However, what the report does state is the need, in larger units, for midwives to train further in the knowledge and skills required for complex labours. Though probably not intended to be necessarily radical, its radical potential can be seen with regards to blurring the professional boundaries. Training in the clinical skills of obstetrics would not render midwives obstetricians. To move beyond the boundaries involves something more; it would involve sustaining the traditional skills of midwives which enables them ideally to be truly 'with woman', but with the clinical expertise so that constituting them as secondary in obstetrical emergencies becomes less and less viable. If such training empowered midwives in relation to obstetricians, does the potential lie here then for a midwifery profession, with all the existing skills in being 'with woman', to engage more with problematic pregnancies, therefore providing for that holistic care necessary? Would this deconstruct the 'otherness' of midwifery to obstetrics that Annandale and Clarke (1996,1997) had suggested questioned its value as an alternative model of childbirth? These are mere speculations. Nevertheless, they are important ones to

engage in given that my research has shown that women experiencing serious complications are rendered mere isolated patients with their holistic needs marginalised.

To recognise the concerns raised by the disease is not necessarily to acquiesce to a medical model of pregnancy and the medical domination which it legitimates. Instead, on a practical level, it presents the opportunity to investigate ways of organising of organising necessary surveillance and intervention in a manner which does not curtail women's autonomy and control. For example, with regard to essential ante-natal testing, possibilities of self-testing could be explored given that some women in the sample who entered subsequent pregnancies decided to do this as a way of feeling that they had some control over this surveillance (Chapter Seven). Some women, like Diane, felt that her further experiences of pre-eclampsia became 'better' as she became more informed about the disease and able to observe for symptoms more effectively as well as feel more empowered to participate in decision-making.

The NICE guideline on antenatal care states that women should receive information but does not explicitly identify this as including information on complications (National Institute for Clinical Excellence, 2003). This lack of specificity regarding complications might reflect the fact that the guideline '...covers the clinical antenatal care of all healthy women with an uncomplicated singleton pregnancy...' (p.23). PRECOG, the pre-eclampsia community guideline, constructed under the auspices of APEC (Milne, 2005) was constructed to compliment the NICE guidance and details an evidence based risk assessment plan. However, despite such a plan and its statement of recognising that '...women's emotional, cultural and midwifery needs should be taken into account when developing care plans...' for women with pre-eclampsia, the way in which this should be fulfilled is not evident. The focus is instead on clinical planning. However, a number of recommendations for practice can be made from the experiences of the women in the

sample and from their own ideas on improvements. Whilst I make these with regards specifically to the issue of pre-eclampsia and to the care of women with this disease, it may well be that some points are generalisable to the broader issue of serious complications of pregnancy.

1. Information regarding pre-eclampsia should be made available to all pregnant women as early as possible. The research has shown, however, that the presentation of such information should be such that it is less easy for women to marginalise it. Thus, pre-eclampsia should constitute more than a brief paragraph but rather be presented as one of the commonest complications of pregnancy. Such information should also have a clear list of symptoms and emphasise the need for regular urine testing and blood pressure monitoring. Information needs to go beyond the written form. All midwives should also explain the link between the routine antenatal testing and pre-eclampsia. Once women are diagnosed with pre-eclampsia, they should receive written and verbal information and midwives should be aware of the need for this information to be repeated. Information on the illness, its treatment and possible consequences should be shared with women.
2. It must be recognised that women with pre-eclampsia, like those with normal pregnancies, have holistic needs which, if met, related to improved emotional outcomes. Thus, having someone to talk to about what is happening and to share their fears and understandings with are important. Information about Befriending services and a help-line through, for example, Action on Pre-eclampsia should be made available.

3. Many of the women in the sample had babies who needed neonatal care. The research has shown some of the difficulties they encountered. Staff should be sensitive to the needs of women whose babies require such care, recognising the emotional distress that might be caused if women are placed alongside others who have experienced uncomplicated pregnancies and who have their babies with them.
4. Some of the women felt that improvements should be made in the care of their own significance others. As Chapter Six also showed, these others themselves sometimes felt alienated. Given their possible role, as Chapter Five showed, as advocating, supporting and 'witnessing' for their wives or partners, there needs to be recognition of their need to also be fully informed and made aware of support mechanisms which exist through groups like APEC.
5. This thesis has revealed the particular experiences of women who have further pregnancies after experiencing pre-eclampsia. It is important for midwives to understand the different strategies that women may adopt upon reconstructing pregnancy as risky. Some women will be more reassured through the ability to access greater levels of medical supervision. Other women may be focussed upon individual strategies and information and support should be available to these. For example, some women may benefit from being encouraged to conduct self testing of urine. They should be made fully aware of the likelihood of a reoccurrence and of symptoms to watch for. Generally, the anxieties of women who previously experienced pre-eclampsia must be recognised and responded to.

A Final Assessment and Review

Based on a study of thirty women who experienced pre-eclampsia, this thesis has mounted both a challenge to existing feminist thinking on medicalised childbirth and the alternative forms of maternity care often promoted from it. How far is this challenge legitimate given the research process underpinning it? This final section of the chapter will consider the potential criticisms of the research and its overall contribution.

The carrying out of the research was influenced, not only by methodological intentions, but by the practical realities and constraints of self-funding, part time studentship and the demands of employment and single parenthood. The obvious impact of this was on the size of the sample. The women in my research are relatively small in number. The significant others included, even smaller in number. The sample was self-selecting. The result was a group of thirty women who were largely middle class and white. Ultimately, this places restrictions upon the degree to which I can generalise my results. Had time and finance been available to me, the sample size would have been larger. Another factor influencing the nature of the sample was the method of recruitment. I began the research wanting to maintain a degree of actual and certainly perceived autonomy from the medical profession. Assuming, wrongly as it turned out, that all women would want to be highly critical of the medical profession, I decided that advertising the research was preferable to seeking contacts with professionals who I risked ultimately being related to through the eyes of the women. I wanted to be perceived by these women as independent in all ways from the medical profession. This would, I reasoned, give them more autonomy and confidence to 'tell it as it really was'. I cannot say whether this autonomy was realised through this method of respondent recruitment. What has of course been realised is a very socially circumscribed sample. Ideally, the women would have reflected a wider range of socio-economic and cultural backgrounds. Nevertheless, the fact that the sample is not broadly

representative of the wider population does not dissuade from the authenticity of the voices included and therefore heard. It is the case rather that I am unable to generalise from these voices. More work would need to be carried out on a wider sample of women in order for any generalisations to be valid.

A second potential criticism of the research is that all the accounts collected were reflections upon past events. Recollections can certainly be distorted with the passage of time and of course be reconstructed in many ways, for many different reasons. What was very clear was that for many of the women, pre-eclampsia was a massively traumatic event. Whilst it could be argued that such trauma impacts upon such recollections, it could also be argued that the fact of its huge significance to women's lives meant that the accounts were more easily relived with greater detail. Moreover, the strength of the accounts collected in this thesis is that women had had the opportunity to reflect on their experiences and to identify with hindsight the most significant aspects from their perspective. Women were open with me when they had not been aware of what had happened to them and the fact that some were keen for me to talk to others who had been witnesses to events confirmed, for me, the authenticity of their accounts. Ultimately, reflective accounts were all that were available to me. As mentioned in Chapter Three, the nature of pre-eclampsia, especially with its first occurrence means that it would have been very difficult to access women for research during the event. Of course, possibilities of longitudinal research are present with women who want to experience further pregnancies. In these circumstances, it would have been possible to capture the reality as it occurred rather than relying solely on personal recollections. Though for some women in my research this could have been a further development within the research design, the practicalities were beyond my means.

Thirdly, what of the credibility of my analysis? In Chapter Three of the thesis I

presented my analysis procedures which I refer to as a grounded theory *informed* analysis strategy rather than a grounded theory analysis *per se*. I also reflected on my own account of pre-eclampsia and its possible implications for the research. I was in no way personally divorced from the research. To what extent does this problematise my analysis? Ultimately, this is something difficult to evidence but in defence of my interpretation of the data I make the following points. Firstly, many of the accounts that I presented contradicted my own experience. Some of the conclusions emerging from Chapter Five through to Chapter Seven are not those expected or reflected in my own account. I have already mentioned, for example, that I expected a greater level of criticism of the medical professionals. The criticism was there though often contextualised by women's understanding of the restrictions placed upon midwives, for example. My own initial criticism was broader and less constrained by considerations of the constraints within which medical professionals work. Secondly, I had only initially been concerned with understanding women's experiences but the emerging data led me to recognise the need to incorporate on an exploratory level the voices of others. I had not been concerned that these voices were unheard. But the women had. My claim to adopt an analytical approach informed in part by grounded theory necessitated that the research and analysis be influenced by the emerging accounts. I suggest therefore that my analysis gains credibility in part through the way in which the conclusions and sample inclusions deviated from my expectations and preferences. On reflection, I recognise that adopting a strategy whereby my conclusions could be considered by the women themselves for confirmation of their validity would have bolstered my final analysis.

A further point to make regarding the credibility of my analysis relates to my broader expectations on beginning the research. These did not include the emergence of risk as a central theme and the need to therefore consider the sociology of risk. Neither did I expect or want to engage in theoretical ideas informed by postmodernism. Risk and

postmodernism are quite simply areas which I had no firm knowledge of nor felt particularly confident engaging with. The analysis of the data, however, led to my having to do this at some level. The difference between my expectations and what emerged from the data gives, I suggest, further credibility to my analysis.

What finally can be claimed about the overall contribution of this thesis? Prior to this thesis there was no sociologically informed research into the experiences of women who had suffered from pre-eclampsia. In conducting this research, therefore, I have given voice to a number of women with varied experiences of pre-eclampsia and considered the implications of their accounts. Though the extent to which these are generalisable has already been noted as problematic, the accounts raise important issues which further research might address and in doing so aid the development of the feminist challenge to medicalised childbirth.

The sample of women who had experienced pre-eclampsia recalled their early expectations of pregnancy and the ways in which these were often transformed through the experience of pre-eclampsia. I have shown how these expectations cannot be understood in terms of an acceptance of one particular model of childbirth. Neither can they simply be understood as representing an accommodation to aspects of supposedly competing models. Indeed, I have suggested that when women express ideas that seem to reflect natural childbirth, rather than such ideas *competing* with the medical model, they are *developed* from that model insofar as risk emerges as a *basis upon* which women construct their ideals.

This finding also had significance in understanding their later conceptions of pregnancy as risk became more central. Fundamentally, this finding raises some important theoretical challenges for the feminist critique and I have suggested in Chapter Eight, the significance

of building on and developing a postmodernist perspective. Thus, the feminist challenge cannot simply be based on the promotion of normality for to do so is, not only to neglect those women whose pregnancies do not conform to such normality, but to give power to that which is being contested: the medical model. I have suggested that notions of risk are always to some degree present in the accounts of the women and that this illustrates the fallacy of assuming that medicalised childbirth can be contested by constructing or promoting models which seemingly oppose it. Women's lived realities are too complex for this.

In considering their experiences of medical intervention what emerged confirmed previous research which revealed that childbearing women had needs beyond the purely physical. Women had holistic needs and wants. My research showed, for example, the significance of understanding women's experiences in a social context within which they account for significant others. These unheard voices played various roles and were considered an important aspect of their experience. Most women were happy with the physical care received; conversely, most were unhappy with what they considered to be important social and psychological care considerations. By confirming this, however, with women in a context of necessary intervention I pose a challenge to the assumption implicit in the focus of much previous work that the promotion of holistic concerns are relevant primarily to women experiencing a normal childbirth. I also raise the challenge of investigating ways of practically meeting these needs in a context of high levels of intervention. The most fundamental question is, therefore, how is it possible for women to experience necessary intensive medical care in a context which does not then dis-empower them? Practically, this is a challenge to all maternity care practitioners. Theoretically, however, it is a challenge to existing feminist critiques which must move beyond binary thinking into a perspective which can indeed engage in this type of question.

Despite the limitations of the research, I believe its main contribution is less the answers it provides, but more the challenges and questions it raises to the existing theoretical critique and existing professional practice. In Chapter Eight I tried to show how postmodernism and insights from the sociology of risk might be embraced to develop the feminist challenge in such a way that does not leave the voices of women with serious complications unheard. While I have not, in this thesis, fully achieved such a development, I hope I have shown the value of this new direction. The goal of a developed feminist challenge to medicalised childbirth remains some way off. The process of attaining it, however, must begin with research. As well as simply more research into women's experiences of a variety of pregnancy complications, I suggest here two possible investigations.

Firstly, if the role of midwife is truly to be 'with woman' then one possible way forward is for this profession to engage more with the abnormal, to develop more knowledge and expertise so as to be confident in promoting the wider needs of women in a situation of necessary obstetrical intervention. Research could be conducted into precisely this possibility.

Secondly, as I have repeatedly stressed, the alternatives promoted by feminists to challenge medicalised childbirth cannot fully accommodate women such as those in my research because their premise is normality. Many ended up dealing with subsequent pregnancies by locating themselves directly within the medical model in terms of their expectations and understandings. This in turn revealed the inability of natural childbirth to provide a language and a care context for women with complications. However, for some women there was evidence of their developing a 'space' within which, despite the context, they could be partially empowered. This was based upon their embodied experiences and developing expertise which gave some of them confidence to ask more questions and

challenge. This raises possibilities of exploring the broadening of this space through equipping women with the necessary knowledge but also options for self monitoring like home urine and blood pressure testing. Again here lie possibilities for further research.

My thesis has revealed the need for further research rather than provided definitive answers. I have been left with a series of conclusions which although necessarily circumscribed are, I suggest, interesting and stimulating. In Chapter Two of the thesis I suggested that Rothman (1982) was wrong in her conclusion that as a sociologist, the option of promoting autonomy and support in a hospital context was unavailable. When one *begins* with the problem of pregnancy complications requiring hospitalisation, such an option is the only one available unless women with serious complications are to be effectively left at the mercy of a system of care which has been shown to be in need of challenge.

As long as complications like pre-eclampsia exist there will be a need for medical intervention. As long as there remains a need for medical intervention then there is a need to research ways of bringing into the hospital social support and promoting women's autonomy whilst they are there. To turn to such concerns involves a shift in the existing premise: that of the normality of pregnancy. This will involve the need to emerge theoretically from the constraints of binary thinking. Pregnancy is not inherently abnormal. But pregnancy can become abnormal. Not to embrace this is to challenge medicalised childbirth in a way which simply reinforces the power of 'medical men' over some women and in this, ultimately over all women.

Bibliography

Abboud, L. and Liamputtong, P. (2005) 'When pregnancy fails: coping strategies, support networks and experiences with health care of ethnic women and their partners', *Journal of Reproductive and Infant Psychology*, 23 (1), pp.3-18.

Action on Pre-eclampsia (2006) *About Pre-eclampsia*, Available from:

<http://www.apec.org.uk/documents/apec/preeclampsia.htm> (Accessed 6 December 2006)

Alderson, P. (2006) 'Parents' experience of sharing neonatal information and decisions', *Social Science and Medicine* 62, pp. 1319-1329.

Annandale, E. (1987) 'Dimensions of patient control in a free-standing birth centre', *Social Science and Medicine*, 25 (11), pp. 1235-48.

Annandale, E. (1998) *The Sociology of Health and Medicine: A Critical Introduction*, Cambridge, Polity Press.

Annandale, E and Clarke, J. (1996) 'What is gender? Feminist theory and the sociology of human reproduction', *Sociology of Health and Illness*, 18 (1), pp.17-44.

Annandale, E and Clarke, J. (1997) 'A Reply to Rona Campbell and Sam Porter', *Sociology of Health and Illness*, 19 (4), pp. 533-534.

Annells, M. (1996) 'Grounded theory method: philosophical perspectives, paradigm of inquiry, and postmodernism', *Qualitative Health Research*, 6(3), pp. 379-393.

Arms, S. (1994) *Immaculate Deception II: A fresh Look at Childbirth*, California, Celestial Arts.

Arney, W. (1982) *Power and the Profession of Obstetrics*, London, University of Chicago Press.

Arney, W and Neill, J. (1982) 'The location of pain in childbirth: natural childbirth and the

transformation of obstetrics', *Sociology of Health and Illness*, 4 (1), pp. 1-24.

Baker, S; Choi, P; Henshaw, C and Tress, J. (2005) 'I felt as though I'd been in jail: women's experiences of maternity care during labour, delivery and the immediate postpartum', *Feminism and Psychology*, 15 (3) pp. 315-342.

Balaskas, J. (1992) *Active Birth: The New Approach to Giving Birth Naturally*, Boston, Harvard Common Press.

Beck, U. (1992) *The Risk Society: On the Way to an Alternative Modernity*, Newbury Park, SAGE.

Becker, H. (1967) 'Whose side are we on?', *Social Problems*, 14 (3), pp. 239-247.

Becker, G and Nachtigall, R. (1994) 'Born to be a mother; the cultural construction of risk in infertility treatment in the U.S.', *Social Science and Medicine*, 39 (4), pp. 507-518.

Bendelow, G. (1993) 'Pain perceptions, emotions and gender', *Sociology of Health and Illness*, 15 (3), pp. 273-295.

Bendelow, G and Williams, S. (1995) 'Transcending the dualism: towards a sociology of pain', *Sociology of Health and Illness*, 17 (2), pp. 139-165.

Blaxter, M. (1999) 'Risk, health and social research: lessons from the ESRC programme on risk and human behaviour', *Health, Risk and Society*, 1 (1), pp. 11-24.

BLISS (2005) *Facts and Figures*. Available from:

http://www.bliss.org.uk/pagebuild.php?texttype=about_factsandfigures (Accessed 12 December 2005)

Bloor, M. (1995) *The sociology of HIV Transmission*, London, SAGE,

Bondas-Salonen, T. (1998) 'How women experience the presence of their partners at the births of their babies', *Qualitative Health Research*, 8 (6), pp. 784-800.

Brooks, F. (1990) *Alternatives to the Medical Model of Childbirth: A Qualitative study of*

Brooks, F. and Lomax, H. (1999) 'Labouring bodies: mothers and maternity policy', in Ellis, K and Dean, H. (1999) *Social Policy and the Body: Transitions in Corporeal Discourses*, London, Macmillan Press.

Bryman, A and Burgess, R. (1994) *Analysing Qualitative Data*, London, Routledge.

Campbell, R and Porter, S. (1997) 'Feminist theory and the sociology of childbirth: a response to Ellen Annandale and Judith Clarke', *Sociology of Health and Illness*, 19 (3), pp. 348-358.

Campbell, R and Wasco, S. (2000) 'Feminist approaches to social science: epistemological and methodological tenets', *American Journal of Community Psychology*, 28 (6), pp. 773-791.

Cartwright, A. (1979) *The Dignity of Labour?: A Study of Childbearing and Induction*, London, Tavistock Publications.

Cixous, H. (1975) 'The Laugh of the Medusa', extract in Humm, M (1992) (Ed.) *Feminisms: A Reader*, London, Harvester Wheatsheaf.

Confidential Enquires into Maternal and Child Health (2004) *Why Mothers Die: 2000-2002*, London, RCOG Press.

Corbin, J and Strauss, A. (1998) *Basics of Qualitative Research*, London, SAGE.

Corbin, J. (1987) 'Women's Perceptions and Management of a Pregnancy Complicated by Chronic Illness', *Health Care for Women International*, 8, pp.317-337.

Cosslett, T. (1991) 'Grantley Dick Read and Sheila Kitzinger: towards a woman-centred story of childbirth', *Journal of Gender Studies*, 1, pp. 29-43

Cusk, R. (2003) 'Modern Madonnas', *New Statesman*, 132 (4625).

De Beauvoir, S. (1974) *The Second Sex*, New York, Vintage Books.

Denscombe, M. (2001) 'Urban identities and health-risking behaviour: the case of young people and smoking in late modernity', *British Journal of Sociology*, 52(1), pp. 157-177.

Denzin, N and Lincoln, Y. (1998a) *Collecting and Interpreting Qualitative Materials*, London, SAGE.

Denzin, N and Lincoln, Y. (1998b) *The Landscape of Qualitative Research: Theories and Issues*, London, SAGE.

Department of Health (1993) *Changing Childbirth: The Report of the Expert Maternity Group*, London, HMSO.

Dick-Read, G. (1953) *Childbirth Without Fear*, London, Heinemann.

Donnison, J. (1977) *Midwives and Medical Men: A history of Inter-Professional Rivalries and Women's Rights*, London, Heinemann.

Doucet, A and Mauthner, N. 'Voice, reflexivity and relationships in qualitative data analysis: Background paper for Workshop on "Voice in Qualitative Analysis".' Available from:

http://www.coe.uga.edu/quig/proceedings/Quig98_Proceedings/doucet_mauthner.html

(Accessed on 11 February 2002).

Doyal, L. (1995) *What Makes Women Sick: Gender and the Political Economy of Health*, London, Macmillan.

Draper, J. (2003) 'Blurring, moving and broken boundaries: men's encounters with the pregnant body', *Sociology of Health and Illness*, 25 (7), pp. 743-767.

Duff, C. (2003) 'The importance of culture and context: rethinking risk and risk management in young drug using populations', *Health, Risk and Society*, 5 (3), pp. 285-299.

Dulude, D; Wright, J. and Belanger, C. (2000) 'The effects of pregnancy complications on the parental adaptation process', *Journal of Reproductive and Infant Psychology*, 18 (1),

Earle, S. (2003) 'Bumps and boobs: fatness and women's experiences of pregnancy', *Women's Studies International Forum*, 26 (3), pp. 245-252.

Elliot, H. (1997) 'The use of diaries in sociological research on health experience', *Sociological Research Online*, 2 (2), Available from:
<http://www.socresonline.org.uk/socresonline/2/2/7.html> (Accessed 22 February 2002).

Enrenreich, B and English, D. (1970) *Witches, Midwives and Nurses: A History of Women Healers*, New York, Feminist Press.

Enrenreich, B and Enrenreich, J. (1978) 'Medicine and social control', in Enrenreich, J, (Ed.) *The Cultural Crisis of Modern Medicine*, New York, Monthly Review Press.

Finch, J. (1993) ' "It's great to have someone to talk to": ethics and politics of interviewing women', in Hammersley, M. *Social Research: Philosophy, Politics and Practice*, London, SAGE.

Finkelstein, J. (1990) 'Women, pregnancy and childbirth', in Scutt, J. *The Baby Machine: Reproductive Technology and the Commercialisation of Motherhood*, London, Merlin Press.

Fontana, A and Frey, J.H. (1998) 'Interviewing: the art of science', in Denzin, N and Lincoln, Y. (1998), *Collecting and Interpreting Qualitative Materials*, London, SAGE.

Foucault, M. (1971) *Madness and Civilisation: A history of Insanity in an Age of Reason*, London, Routledge.

Fox, B and Worts, D. (1999) 'Revisiting the critique of medicalised childbirth: a contribution to the sociology of birth', *Gender and Society*, 13 (3), pp. 326-347.

Glasner, B and Strauss, A. (1967) *Discovery of Grounded Theory*, Chicago, Aldine.

Graham, H. (1977) 'Images of Pregnancy in Antenatal Literature', in Dingwall, R; Heath, C and Stacey, M. *Health Care and Health Knowledge*, London, Croom Helm.

- Graham, H and Oakley, A. (1981) 'Competing ideologies of reproduction: medical and maternal perspectives on pregnancy', in Roberts, H (Ed), *Women, Health and Reproduction*, London, Routledge and Kegan Paul.
- Green, E, Thompson, D and Griffiths, F. (2002) 'Narratives of risk: women at midlife, medical 'experts' and health technologies', *Health, Risk and Society*, 4 (3), pp. 276-285.
- Green, J. (1998) 'Commentary: Grounded theory and the constant comparative method', *British Medical Journal*, 316 (7137), pp. 1060-64.
- Green, J and Bastan, H. (2003) 'Feeling in control during labour: concepts, correlates and consequences', *Birth: Issues in Perinatal Care*, 30 (4), pp. 235-247.
- Haire, D. (1978) 'The cultural warping of childbirth', in Enrenreich, J, *The Cultural Crisis of Modern Medicine*, London, Monthly Review Press.
- Hammersley, M. (1993) *Social Research: Philosophy, Politics and Practice*, London, SAGE.
- Harding, S. (Ed) (1987) *Feminism and Methodology*, Milton Keynes, Open University Press.
- Hobson-West, P. (2003) 'Understanding vaccination resistance: moving beyond risk', *Health, Risk and Society*, 5(3), pp. 273-283.
- Illich, I. (1976) *Limits to Medicine*, London, Calder and Boyars.
- Jayarante, T. (1993) 'The value of quantitative methodology for feminist research', in Hammersley, M. *Social Research: Philosophy, Politics and Practice*, London, SAGE.
- Jones, L.J. (1994) *The Social Context of Health and Health Work*, London, Macmillan.
- Jones, K. (2000) 'The unsolicited diary as a qualitative research tool for advanced research capacity in the field of health and illness', *Qualitative Health Research*, 10 (4), pp. 555

- Jordan, K; Capdevila, R and Johnson, S. (2005) 'Baby of beauty: a Q study into post pregnancy body image', *Journal of Reproductive and Infant Psychology*, 23(1), pp.19-31.
- Kahn, R. (1995) *Bearing Meaning: the Language of Birth*, Chicago, University of Illinois Press.
- Katona, C. (1982) 'Approaches to antenatal education', *Social Science and Medicine*, 15A, pp. 25-33.
- Kendall, J. (1999) 'Axial coding and the grounded theory controversy', *Western Journal of Nursing Research*, 21 (6), pp. 743-57.
- Kirk, S. (1994) 'The needs of women hospitalised in pregnancy', in Robinson, S. and Thomson, A. (Eds.) *Midwives, Research and Childbirth, Volume 3*, London, Chapman and hall.
- Kirkham, M. (1986) 'A feminist perspective in midwifery' in Webb, C. *Feminist Practice in women's Health Care*, Chichester, John Wiley and Sons.
- Kirkham, M and Stapleton, H. (2004) 'The culture of the maternity services in Wales and England as a barrier to informed choice', in Kirkham, M (Ed.) (2004) *Informed Choice in Maternity Care*, Hampshire, Palgrave.
- Kirsi, V. (2000) 'The moral dangers of home birth: parents perceptions of risks in home birth', *Sociology of Health and Illness*, 22 (6), pp. 792-814.
- Kitzinger, S. (1972) *The Experience of Childbirth*, Harmondsworth, Penguin.
- Kitzinger, S. (1984) *The Experience of Childbirth*, Harmondsworth, Penguin.
- Kitzinger, S. (1992) 'Birth and violence against women: Generating hypotheses from women's accounts of unhappiness after childbirth', in Roberts, H (Ed), *Women's Health Matters*, Edinburgh University Press.
- Kvale, S. (1996) *Interviews: An Introduction to Qualitative Research Interviewing*, London, SAGE.

Lane, K. (1995) 'The medical model of the body as a site of risk: a case study of childbirth', in Gabe, J, (Ed.), *Medicine, Health and Risk*, Oxford, Blackwell.

Lamaze, F. (1958) *Painless Childbirth*, London, Burke.

Lamaze International (2006) *Lamaze Institute for Normal Birth*, Available from: <http://www.lamaze.org/institute/> (Accessed 5 August 2006)

Lankshear, G; Ettorre, E and Mason, D. (2005) 'Decision-making, uncertainty and risk: exploring the complexity of work processes in NHS delivery suites', *Health, Risk and Society*, 7 (4), pp. 361-377.

Lawson, R and Rajaram, S. (1994) 'A transformed pregnancy-the psychosocial consequences of gestational diabetes', *Sociology of Health and Illness*, 16 (4), pp. 536-562.

Layne, L. (1997) 'Breaking the silence: an agenda for a feminist discourse of pregnancy loss', *Feminist Studies*, 23 (2), pp. 289-315.

Layne, L. (2003) 'Unhappy endings: a feminist reappraisal of the women's health movement from the vantage point of pregnancy loss', *Social Science and Medicine*, 56 (9), pp. 1881-1891.

Leap, N. and Hunter, B. (1993) *The Midwives Tale: An Oral History from Handywoman to Professional Midwife*, London, Scarlet Press.

Lipson, J. and Rogers, J. (2000) 'Pregnancy, birth and disability: women's health care experiences', *Health Care for Women International*, 21, pp.11-26.

Lovell, A. (1983) 'Some questions of identity: late miscarriage, stillbirth and perinatal loss', *Social Science and Medicine*, 17 (11), pp.755-761.

Luhmann, N. (1993) *Risk: A Sociological Theory*, New York, Walter de Gruyter.

Macintyre, S. (1977) 'The management of childbirth: a review of sociological issues',

Social Science and Medicine, 11, pp. 477-484.

Marshall, C. and Rossman, B. (1993) *Designing Qualitative Research*, London, SAGE.

Marshall, H and Wollett, A. (2000) 'Fit to reproduce? The regulative role of pregnancy texts', *Feminism and Psychology*, 10 (3), pp. 351-366.

Martin, E. (1992) *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston, Beacon Press.

Maticka-Tyndale, E. (1992) 'Social construction of HIV transmission and prevention among heterosexual young adults', *Social Problems*, 39 (3), pp.238-52.

May, T. (1993) *Social Research: Issues, Methods and Processes*, Buckingham, Open University Press.

Maykut, P and Morehouse, R. (1994) *Beginning Qualitative Research: A Philosophic and Practical Guide*, London, Routledge/Falmer.

McCreight, B. (2004) 'A grief ignored: narratives of pregnancy loss from a male perspective', *Sociology of Health and Illness*, 26 (3), pp. 326-350.

McKeown, T. (1979) *The Role of Medicine*, Oxford, Blackwell.

Melia, K. (1996) 'Rediscovering Glaser', *Qualitative Health Research*, 6(3), pp.368.

Mies, M. (1993) 'Towards a Methodology of Feminist Research', in Hammersley, M (Ed) *Social Research: Philosophy, Politics and Practice* London, SAGE.

Miles, M and Huberman, M. (1994) *Qualitative Data Analysis: A Sourcebook of New Methods*, London, SAGE.

Miles, A. (1991) *Women, Health and Medicine*, Buckingham, Open University Press.

Miller, J and Glasner, B. (1997) 'The Inside' and 'The Outside': finding realities in interviews', in Silverman, D. (ed.) *Qualitative Research: Theory Method and Practice*,

London, SAGE.

Milne, F. (2005) 'The pre-eclampsia community guideline (PRECOG):how to screen for and detect onset of pre-eclampsia in the community', *British Medical Journal*, 330, pp. 576-580.

Monto, M. (1997) 'The lingering presence of medical definitions among women committed to natural childbirth', *Journal of Contemporary Ethnography*, 26 (3), pp. 293-316.

Moscucci, O. (2003) 'Holistic obstetrics: the origins of natural childbirth in Britain', *Postgraduate Medical Journal*, 79, pp. 168-173.

Mutryn, C. (1993) 'Psychosocial impact of caesarean section on the family: a literature review', *Social Science and Medicine*. 37 (10), pp. 1271-1281.

Nelson, M. (1983) 'Working-class women, middle-class women, and models of childbirth', *Social Problems*, 30, pp. 284-297.

Nettleton, S. (1995) *Sociology of Health and Illness*, Cambridge, Polity Press.

Nettleton, S. (1997) 'Governing the risky self: how to become healthy, wealthy and wise', in Peterson, A and Bunton, R. (Eds.) *Foucault, Health and Medicine*, London, Routledge.

National Institute for Clinical Excellence (2003) *Antenatal Care: Routine care for the healthy pregnant woman*, London, NICE.

Oakley, A. (1979a) *From Here to Maternity*, Harmondsworth, Penguin.

Oakley, A. (1979b) 'A case of maternity: paradigms of women as maternity cases', *Journal of Women in Culture and Society*, 4, (4), pp. 606-631.

Oakley, A. (1980) *Women Confined: Towards a Sociology of Childbirth*, Oxford, Martin Robertson.

Oakley, A. (1981) 'Interviewing Women: a Contradiction in Terms', in Roberts, H (Ed).

Doing Feminist Research, London, Routledge and Kegan Paul.

Oakley, A. (1984) *The Captive Womb: A History of the Medical Care of Pregnant Women*, Oxford, Basil Blackwell.

Oakley, A. (1986) 'Feminism, motherhood and medicine-who cares?', in Mitchell. J and Oakley, A (Eds.), *What is Feminism?* Oxford, Basil Blackwell.

Oakley, A. (1993a) *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Oakley, A. (1993b) 'Birth as a 'normal' process', in Oakley, A, *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Oakley, A. (1993c) 'Who cares for women? science and 'love' in midwifery today', in Oakley, A, *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Oakley, A. (1993d) 'Promoting the health of childbearing women', in Oakley, A, *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Oakley, A. (1993e) ' 'Consumerism' and the future of perinatal health services', in Oakley, A, *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Oakley, A. (1993f) 'Perinatal mortality: whose problem?', in Oakley, A, *Essays on Women, Medicine and Health*, Edinburgh, Edinburgh University Press.

Office for National Statistics (2000a) *Standard Occupational Classification 2000* Available from:

http://www.statistics.gov.uk/methods_quality/ns_sec/soc2000.asp (Accessed 28 November 2006)

Office for National Statistics (2000b) *Introduction: the National Statistics Socio-economic Classification* Available from:

http://www.statistics.gov.uk/methods_quality/ns_sec/default.asp (Accessed 28 November 2006)

Quinn, R; Gutek, B and Walsh, J. (1980) 'Telephone interviewing: a reappraisal and a field experiment', *Basic and Applied Social Psychology*, 1(2), pp. 127-153.

Reid, M; Lloyd, D; Campbell, G; Murray, K and Porter, M. (1995) 'Scottish neonatal intensive care units; a study of staff and parental attitudes', *Health Bulletin*, 53 (5), pp.314-325.

Reinharz, S and Davidman, L. (1992) *Feminist Methods in Social Research*, Oxford, Oxford University Press.

Riessman, C. (1992) 'Women's Medicalisation: A New Perspective', in Kirkup, G and Keller, L. (Eds.) *Science, Technology and Gender*, Cambridge, Polity Press.

Risman, B. (1993) 'Methodological implications of feminist scholarship', *American Sociologist*, 24 (93),pp. 15-25.

Roberts, J.M and Redman, C.W. (1993) 'Pre-eclampsia: more than pregnancy-induced hypertension', *Lancet*, 342(8869),p.504.

Robrecht, L. (1995) 'Grounded theory: evolving methods', *Qualitative Health Research*, 5 (2), pp.169-177.

Rose, K and Webb, C. (1998) 'Analysing data: maintaining rigor in a qualitative study', *Qualitative Health Research*, 8 (4), pp. 556-562.

Rothman, K. (1982) *In Labour: Women and Power in the Birth Place*, London, Junction Books.

Rothman, K. (1986) *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*, London, Pandora.

Royal College of Midwives (2005) *Definition and the RCM Position Paper* Available from:

<http://www.rcmnormalbirth.net/default.asp?sID=1103625596157> (Accessed 12 November 2006).

Royal College of Obstetricians and Gynecologists and Royal College of Midwives (1999) *Towards Safer Childbirth*, London, RCOG.

Sandall, J. (1995) 'Choice, continuity and control: changing midwifery towards a sociological perspective', *Midwifery*, 11, pp. 201-209.

Scambler, G. (Ed) (1991) *Sociology as Applied to Medicine*, London, Bailliere Tindall.

Sculley, D. (1980) *Men Who Control Women's Health: The Mis-education of Obstetricians and Gynaecologists*, Boston, Houghton Mifflin.

Short, J. (1984) 'The social fabric at risk: towards the social transformation of risk analysis', *American Sociological Review*, 49, pp.711-725.

Silverman, D. (1985) *Qualitative Methodology and Sociology*, Hants, Gower.

Smith, E. (2005) 'Telephone interviewing in healthcare research: a summary of the evidence', *Nurse Researcher*, 12 (3)

Stanley, L. (Ed.) (1990) *Feminist Praxis: Research, theory and Epistemology in Feminist Sociology*, London, Routledge.

Stanley, L and Wise, S. (1983) *Breaking out: Feminist Consciousness and Feminist Research*, London, Routledge and Kegan Paul.

Stanley, L and Wise, A. (1990) 'Method, methodology and epistemology in feminist research processes', in Stanley, L (Ed.). *Feminist Praxis: Research, theory and Epistemology in Feminist Sociology*, London, Routledge.

Stewart, M. (Ed) (2004) *Pregnancy, Birth and Maternity Care*, London, Books for Midwives.

Sturges, J and Hanrahan, K. (2004) 'Comparing telephone and face-to-face interviewing: a research note', *Qualitative Research*, 4 (1): pp. 107-118

- Szasz, T. (1974) *The myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York, Harper and Row.
- Taylor, S and Bogdan, R. (1984) *Introduction to Qualitative Research Methods: The Search for Meaning*, Chichester, John Wiley and Sons.
- Taylor, J. (2000) 'Of sonograms and baby prams: prenatal diagnosis, pregnancy and consumption', *Feminist Studies*, 26 (2).
- Tesch, R. (1990) *Qualitative Research: Analysis Types and Software Tools*, London, Falmer.
- Thomas, C. (1997) 'The baby and the bath water: disabled women and motherhood in social context', *Sociology of Health and Illness*, 19 (5), pp.622-643.
- Thomas, H. (2003) 'Pregnancy, illness and the concept of career', *Sociology of Health and Illness*, 25, pp.383-407.
- Thomas, H. (2004) 'Women's postnatal experience following a medically complicated pregnancy', *Health Care for Women International*, 25, pp.76-87.
- Thompson, L. (1992) 'Feminist methodology for family studies', *Journal of Marriage and the Family*, 54 (1), pp. 3-17.
- Tierney, K. (1999) 'Towards a critical sociology of risk', *Sociological Forum*, 14 (2), pp. 215-242.
- Turner, B. (1984) *The Body and Society*, London, SAGE.
- Weber, M. (1949) *Methodology of the Social Sciences*, New York, Oxford University Press.
- Weitz, R and Sullivan, D. (1985) 'Licensed lay midwifery and the medical model of childbirth', *Sociology of Health and Illness*, 7 (1), pp.36-54.
- Westkott, M. (1990) 'Feminist criticism of the social sciences', in Nielsen, J. (Ed),

Feminist Research Methods, London, West View Press.

Wilkins, R. (1993) 'Taking it personally: a note on emotion and autobiography', *Sociology*, 27 (1), pp. 93-100.

Williams, K and Umberson, D. (1999) 'Medical technology and childbirth: experiences of expectant mothers and fathers', *Sex Roles*, 41 (314), pp. 147-168.

Williams, S and Bendelow, G. (1998) *The Lived Body: Sociological Theories, Embodied Issues*, London, Routledge.

Witz, A. (1992) *Professions and Patriarchy*, London, Routledge.

Wolf, N. (1990) *The Beauty Myth: How images of Beauty are Used against Women*, New York, HarperCollins.

Wolf, N. (2002) *Misconceptions*, London, Vintage.

Wong, M. (1998) 'The ethics of rapport: institutional safeguards, resistance and betrayal', *Qualitative Enquiry*, 4 (2), pp. 178-199.

Wuest, J. (1995) 'Feminist grounded theory: an exploration of the congruency and tensions between two traditions in knowledge discovery', *Qualitative Health Research*, 5(1), pp.125-137.

Zadoroznyj, M. (1999) 'Social class, social selves and social control in childbirth', *Sociology of Health and Illness*, 21 (3), pp. p.267

Zadoroznyj, M. (2001) 'Birth and the 'reflexive consumer': trust, risk and medical dominance in obstetric encounters', *Journal of Sociology*, 37 (2), pp.117-139.

Zinn, J. (2004) *Literature Review: Sociology and Risk*, Working Paper, Social Contexts and Responses to Risk Network, Kent.

Zola, I. (1972) 'Medicine as an institution of social control', *Sociological Review*, 20, pp.487-504.

Biographical Profiles

All names are pseudonyms and information was that supplied at the time of the fieldwork.

Amanda

She was 30 weeks pregnant when diagnosed and had her baby by an emergency caesarean at 31 weeks. Her baby stayed in neonatal care for 10 weeks. She had a second child with no complications.

Angela

She experienced pre-eclampsia in her first pregnancy and her baby died. She sent me some notes on her aftercare but found it too difficult to provide an account of her illness and the baby's death. However, she and her husband, Alex, agreed to my having a copy of the diary that he had kept during that time and this is considered in Chapter Six.

Anne

Anne was 27 weeks pregnant when diagnosed and ended up on full life support after suffering from an eclamptic fit and spent 3 weeks in hospital. She didn't see her baby for 4 days. The baby spent over 8 months in neonatal care and needed oxygen for 2 years. Anne required blood pressure medication for 6 months after the birth.

Belinda

She was diagnosed at 28 weeks and had her baby by emergency caesarean at 34 weeks. She had to spend over 7 weeks in hospital, her baby 3 weeks. Belinda's husband Steve was interviewed for the research also and his account is considered in Chapter Six.

Bella

After going into labour at 40 weeks, Bella suffered 2 eclamptic fits. She had no previous signs of pre-eclampsia. She spent 1 week in hospital and her baby stayed in neonatal care for 4 days.

Brenda

She experienced pre-eclampsia twice with both being born by caesarean at 28 weeks gestation. One of her babies had to spend over 3 months in a neonatal unit.

Carol

She developed swollen ankles at 27 weeks and was sent to hospital for a week after her GP also detected high blood pressure.

Cerri

Cerri had two children at the time of her interview. She suffered pre-eclampsia in the first pregnancy in 1995 and had a caesarean delivery. She spent 12 days in hospital, 3 of which were in the high dependency unit. Her baby spent 16 days in neonatal care. She was unaware of any other family member having suffered the illness.

Diane

Diane had previously been a nurse and at the time of the interview was an antenatal teacher. She experienced pre-eclampsia three times spending on average three weeks in hospital with each experience. None of her babies had to go into a neo natal unit.

Ellen

She suffered from the illness in both of her pregnancies. After the first time she felt that she was led to believe that she would not experience pre-eclampsia again. Both of her babies were born premature.

Emma

She was 26 weeks pregnant when diagnosed and had an emergency caesarean at 27 weeks. Her son weighed 2 pounds. She spent 10 days in hospital. Emma's only overt symptoms were swollen hands and feet.

Fran

She was 28 weeks pregnant when diagnosed with pre-eclampsia in her first pregnancy. She spent over two weeks in hospital and her baby stayed in neonatal care for two months. Her maternal aunt had suffered from pre-eclampsia. Fran's husband John took part in the research by supplying a solicited written account. This is considered in Chapter 6.

Irene

She was the only Black Caribbean woman in the sample. Her account showed no obvious variation to the others. She became ill at 22 weeks into her pregnancy with high blood pressure and swelling. Her baby was delivered at 28 weeks by emergency caesarean, spending 9 weeks in neonatal care. Irene spent a further 10 days in hospital after the birth. The swelling took 6 weeks to subside.

Jane

At 27 weeks she experienced swollen ankles and a pain below her ribs. This was followed by vomiting and headaches. After arriving at hospital she was told that her baby would have to be delivered. Jane spent time on the high dependency unit.

Joanne

She first experienced the symptoms of pre-eclampsia 29 weeks into her pregnancy and needed a caesarean at 32 weeks. She developed whole body swelling. The baby spent 3 weeks and Joanne 2 weeks in hospital.

Julie

She experienced the illness in her first and only pregnancy at 31 weeks with the baby being delivered by caesarean section at 35 weeks. Julie spent 6 weeks in hospital as her blood pressure was trying to be controlled.

Kari

She already had a 4 year old son when in her second pregnancy she experienced high blood pressure at 25 weeks. She was admitted to hospital for 2 weeks and after returning home developed visual symptoms. She was re-admitted and within hours had an emergency caesarean. She spent 8 days in hospital and her daughter needed neonatal care for 4 weeks.

Linda

Linda experienced pre-eclampsia in both of her pregnancies, being diagnosed at 29 and 30 weeks. Both her babies were born by caesarean section and spent time in neo natal care. Linda, at the time of the research was a full time housewife. As far as she was aware, no other members of her family had experienced pre-eclampsia.

Lorraine

She was diagnosed with pre-eclampsia at 35 weeks and had a caesarean. She spent 7 days in hospital.

Mags

She started to develop high blood pressure 7 weeks prior to her due date. She went into hospital for 1-2 night stays on 5 occasions. On her due date she was induced but the babies heart rate dropped and a caesarean was carried out. She spent 10 days in hospital and the baby, 5 days in neonatal care.

Mary

She suffered from pre-eclampsia in her first pregnancy at 26 weeks and the baby was born at 29 weeks. She went on to have another two children with no further problems. She was in hospital for three weeks before the birth and one week after.

Nadine

She experienced pre-eclampsia in both of her pregnancies at 34 and 36 weeks.

Pat

Pat has 4 children and suffered from pre-eclampsia in her 4th pregnancy only. At 20 weeks her blood pressure began to rise and she was hospitalised for 7 days. At 27 weeks she was again admitted and developed HELLP syndrome and spent 3 days in intensive care. Her baby was born by emergency caesarean and stayed in neonatal care for 16 weeks.

Pauline

She experienced pre-eclampsia twice. Her second experience led to the death of her son from complications of prematurity, aged 11 days.

Sandra

Sandra suffered from pre-eclampsia in her fourth pregnancy when she was 28 weeks pregnant. She spent 8 days in hospital but her baby had to spend over 5 months in neonatal care. Sandra's grandmother had suffered from pre-eclampsia.

Sharon

In the 5th month of pregnancy she began to experience swelling and her blood pressure increased. She was admitted to hospital at 27 weeks and her baby was delivered by caesarean at 36 weeks. Sharon had to remain on oxygen for a day after delivery. Her baby spent 9 weeks in neonatal care.

Suzanne

She suffered from pre-eclampsia in both of her pregnancies. With her first pregnancy she was hospitalised with high blood pressure before being induced. She became very ill after the birth and was referred to a kidney specialist. Her blood pressure took 4 months to stabilise. Her second baby was born weighing less than 3 pounds when she was 30 weeks into her pregnancy.

Terri

She spent 3 weeks in hospital prior to having her son by caesarean. After initially inducing her at 38 weeks, she suffered liver and kidney failure, spending 3 days in intensive care and needing a caesarean. She spent 5 days in hospital. Her baby did not require neonatal care. Terri's mum, Jane, was also interviewed for the research and her experience is considered in Chapter Six.

Tracey

Her account did not record. She had suffered pre-eclampsia in both of her pregnancies; one baby was born at 28 weeks, the other at 35 weeks.

APPENDIX 2

HUMAN PARTICIPANTS AND MATERIALS ETHICS COMMITTEE (HPMEC) PROFORMA

Title of project

A short, descriptive title.

The Experience of Pre-eclampsia: Implications for Theory and Maternity Policy

Schedule

Time frame for the research and its data collection phrase(s).

I registered as a part time doctoral student in 1998. The field work began in 2000 and was completed in 2002.

Abstract

A summary of the main points of the research, understandable by a non-specialist.

The research is concerned with revealing and exploring women's experiences of pre-eclampsia. There is a continuing void in the sociological literature concerning serious complications of pregnancy and the ways in which the exploration of such experiences may contribute to the existing feminist critique of medicalised childbirth. Based on the experiences of 30 women, the research has revealed their changing perceptions of pregnancy, the physical and emotional experience and consequences of the disease and their ideas on how improvements might be made to the care received by such women in the future. Semi structured interviewing, personal and telephone, was the primary method and some women chose to supply written accounts of their experiences guided by the thematic scheme of the interview schedule. The research seeks to make a contribution to the wider feminist concern with empowering women within maternity care as well as, on a more theoretical level, challenging the assumptions that have provided the foundation for the existing critique of maternity care.

Source(s) of funding

Details of the external or internal funding body (e.g. ESRC, MRC).

A part time doctoral student. Self funded.

Justification for research

What contribution to knowledge, policy, practice, and people's lives the research will make?

In terms of knowledge, this research will fill the void in the existing literature concerning women's experience of problematic pregnancies. Theoretically, the concern with understanding the many dimensions to this experience contributes critically to the existing feminist critique of medicalised childbirth; a critique so far premised upon an intentional or otherwise neglect of this area. There will also be a discussion of the practical implications for health professionals; in turn providing, potentially, a contribution to improved care services for women who suffer from serious pregnancy complications.

Investigators

Give names and units of all persons involved in the collection and handling of individual data. Please name one person as Principal Investigator (PI).

Principal Investigator: Julie Savage

Supervisors: Professor Celia Davies and Dr Fiona Brooks. Supervisors will not expect to see the data on individuals.

Published ethical guidelines to be followed

For example: BERA, BPS, BSA (see Research Ethics web site for more information).

The British Sociological Association guidelines have been consulted and will be adhered to throughout the study.

Location(s) of data collection

Give details of where and when data will be collected. If on private, corporate or institutional premises, indicate what approvals are gained/required.

Interviews were carried at participant's homes or via telephone conversations to their homes. Some participants produced written accounts of their experiences.

Participants

Give details of the population from which you will be sampling and how this sampling will be done.

The sample consists of 32 women living in the Hertfordshire and North London area who had suffered pre-eclampsia within the previous two years of the commencement of the research. The sample was self selecting. The accounts of 6 significant others were collected; 3 husbands and 3 mothers of the women in the original sample.

Recruitment procedures

How will you identify and approach potential participants?

The research was advertised in a national pregnancy magazine (Babycare and Pregnancy) and the newsletters of two interested charities: BLISS (Baby Life Support Systems) and APEC (Action on Pre-eclampsia). Women who were interested were asked to write or telephone me directly although those potentially recruited through the pregnancy magazine sent their letters directly to the Editor who then forwarded them en masse unopened. Additional interviews were conducted and further written accounts collected with some of the women's husbands and mothers as this aspect emerged as significant in the original interview set.

Consent

Give details of how informed consent will be gained and attach copies of information sheet(s) and consent form(s). Give details of how participants can withdraw consent and what will happen to their data in such a case (see the Research Ethics web site for an advisory document).

When women contacted me regarding the research they were fully informed in writing as to its purpose and my status as a student. They were assured that their account would remain anonymous. The letter had a consent form attached (Appendix A). Some women felt unable or unwilling to be interviewed on a personal one to one basis and were then given the option of engaging in a telephone interview or producing a written account. Such women were sent another form to indicate which medium they were willing to consent to as participants in the research (Appendix B). Interviews with women's 'significant others' were established through firstly, informing women of my hope to collect accounts from their 'significant others' (Appendix C) and securing consent from the women themselves that it was appropriate for me to make initial contact with them (Appendix D) and secondly, forwarding information regarding the research and seeking consent from these 'significant others' (Appendix E).

Methodology

Outline the method(s) that will be employed to collect and analyse data.

Semi structured interviewing was the primary method to collect data. Such interviews were conducted on a one to one personal basis or via the telephone. Soliciting written accounts, guided by the thematic scheme of the interview schedule, was the second method used. One man also forwarded me the diary he wrote during his wife's illness and up to the death of his baby son. Questionnaires designed to identify the socio-economic, ethic and other relevant characteristics of participants were also used (Appendix F), with a covering explanatory letter (Appendix G)

Data Protection

Give details of registration of the project under the DP Act and the procedures to be followed re: storage and disposal of data to comply with the Act.

All data has been stored in a locked filing cabinet. Only pseudonyms are indicated on the cassettes and transcripts. All the data will be destroyed after two years to allow time for any further analysis for publication.

Recompense to participants

Normally, recompense is only given for expenses and inconvenience; otherwise it might be seen as coercion/inducement to participate. Give details of any recompense to participants.

No recompense was offered and therefore provided.

Deception

Give details of the withholding of any information from participants, or misrepresentation or other deception that is an integral part of the research. Any such deception should be fully justified.

No deception or misrepresentation was involved.

Risks

Detail any foreseen risks to participants or researchers and steps that will be taken to minimise/counter these.

The risks considered and engaged with were the possible negative emotional consequences to women of revealing and re-living a sensitive experience. Women were told they could withdraw at any time from the research, including during the interview process. They were also assured that the recording of the interview could be, at any time, suspended or stopped. I went to each interview with various literatures which included help lines for women who had suffered pre-eclampsia. These were offered to all women.

Debriefing

Give details of how information will be given to participants after data collection to inform them of the purpose of their participation and the research more broadly.

All potential participants were informed prior to their actual participation about the nature of the research and what it would involve for them. Thank you letters were sent after each interview or upon receipt of written accounts with contact details should they have any further questions (Appendix H). All participants were told that they would receive a summary version of the research and this commitment will be honoured.

Declaration

Declare here that the research will conform to the above protocol and that any significant changes or new issues will be raised with the HPMEC before they are implemented. A Final Report form will need to be filled in once the research has ended.

Signature(s)

(this can be the typed name(s) of investigator(s) if electronic copy is submitted (which is preferred))

Julie Savage

Date

15th September

**Proposed date for
final report**

End of September, 2006

APPENDIX 3

I have looked through these documents and consider that the protocol and additional documents indicate that student researcher has complied with the requirements of the BSA and broadly with the expected ethical standards of the Open University Human Participants and Materials Ethics Committee. If this had been submitted as a request for formal approval, I expect that the student would have been asked to:

- a) Add to the consent form additional contact details for a third party (e.g. one of the supervisors) who could be approached in the event of any issues arising for a participant that could not be resolved by the student
- b) State explicitly in the information sheet that participants had the right at any time to withdraw from the study and have their data destroyed if they so requested
- c) Include in the risk assessment a consideration of the locations of data collection, recognising the problems associated with interviewing people in their own homes

I hope that this is helpful. I would be happy for these observations to be shared with the student.

APPENDIX 4

My Name
My Address
My Telephone Number

Dear

Thank you for requesting more information about my research into women's experience of pre-eclampsia. The research is being carried out as part of a research degree which I am undertaking through the Open University. The main aim of the research is to find out about your views and experiences of the health care that you received.

I would like to talk to you for about one hour and this would probably take place within your own home or, if you prefer, some other agreed setting. The discussion will be informal, taking the form of a conversation rather than 'question and answer' session. With your permission I would like to record our conversation using a tape machine. **At no point will your name be written or verbally communicated to anybody else. If you agree to participate I can assure you of complete confidentiality and anonymity.** I will use pseudonyms ('false' names), to label the cassettes used for the recording and, with your permission, will relate these to your name and address separately for the purposes of further contact. **This will not be done if that is your wish and you may request that no further contact is made.**

I hope very much that you decide to participate in the research. I hope to actually begin interviewing from Easter 2000 onwards. Please complete the attached form to indicate your choice and return it to me in the stamped and addressed envelope provided. I will then contact you regarding dates and times that are convenient to you.

At any point prior or during the interview you are completely free to decide not to participate any longer.

Thank you for your help.

Yours sincerely,

Julie Savage

I would like to take part ()

I would not like to take part ()

Name:

Contact address:.....

Telephone (optional):.....

I will contact you to arrange a time that is convenient for you.

APPENDIX 5

My Name
My Address
My Telephone Number

Dear,

I am writing to thank you for your participation in the study of women's experiences of pre-eclampsia. Your account of your experiences was very interesting and is very important for the research. Thank you very much for the time that you gave me and for your interest in the study. If you have any further questions about the research in general or any concern about your contribution to it please do not hesitate to contact me either by writing to the above address or by telephoning me on (my telephone number). Once again, thank you for your help and I wish you well.

Yours sincerely,

Julie Savage

APPENDIX 6

My Name
My Address
My Telephone Number:

Dear

Thank you for very much for your recent participation in my research on women's experience of pre-eclampsia. I would again be grateful if you could give me further help by completing the enclosed questionnaire. The questions allow me to understand about the different types of people who have been helping me with the research. **I can assure you that your responses are completely confidential and are for statistical purposes only.** I have enclosed a stamped and addresses envelope for you to return your completed questionnaire.

Thank you once more for your invaluable contribution. I hope very much that you are able to contribute by completing the questionnaire.

If you do not wish to complete the questionnaire, please fill in the space for your name and address and forward it to me using the enclosed envelope.

With kind regards,

Julie Savage

APPENDIX 7

Could you please complete the questions below? Your responses will be completely confidential and are being requested to help me understand about the different types of people who are helping me with the research.

Name:

Address:

Please respond to the following questions by placing a tick in the relevant bracket

- a) How old are you**
- | | |
|-------------------|------------|
| Under 19 | () |
| 20 - 24 | () |
| 25 - 29 | () |
| 30 - 34 | () |
| 35 or over | () |

- b) Is the baby that you experienced pre-eclampsia with your first? (Please include any babies who have died in your response).**

Yes ()

No () Please answer questions b1 and b2

- b1) How many other children do you have:**

One more	()
Two more	()
Three or more	()

- b2) How many times have you previously experienced pre-eclampsia:**

One time previously	()
Twice previously	()
Three times or more	()

c) Have any other members of your family suffered from pre-eclampsia (earlier known as toxemia):

No ()
Mother ()
Grandmother ()
Other

d) Which person/persons were with you the most during your experience of pre-eclampsia?

Husband/partner/boyfriend ()
Mother ()
Father ()
Friend ()
Other

Do you feel that this person may be willing to talk to me about their experience of your illness?

Yes () I may contact you about this
No ()

e) Do you and your household own or rent the house/flat where you live:

Own or are buying ()
Rent or live rent free ()

f) Thinking about yourself, do you have any qualifications at 'A' Level or above:(include NVQ and GNQ Advanced Level)

No ()
Yes ()

g) What is your occupation (or previous occupation if you do not work)?

Current occupation
Previous occupation
Never worked ()

h) What is the occupation of your partner/husband?

i) Do any of the people listed below live with you in your household? TICK ALL WHICH APPLY

Husband/partner/boyfriend ()
Mother and/or father ()

Your children ()
Others
Live alone ()

J) Could you please indicate the income bracket (in pounds) that you and your household come within?

Under 8,000
8,000 - 13,000
14,000 - 19,000
20,000 - 25,000
Over 26,000

k) To which of these ethnic groups do you belong? TICK ONE BRACKET ONLY

White ()
West Indian ()
Indian ()
Pakistani ()
Bangladeshi ()
African ()
Arab ()

Other group or groups (please tick and describe) ()

Thank you very much for completing this questionnaire. Please return it to me using the stamped and addresses envelope provided.

APPENDIX 8

My Name
My Address
My Telephone Number
27th March, 2001

Dear,

I hope you are well and do not mind me contacting you again. I have now collected all the accounts of women's experience of pre-eclampsia and, as stated in the questionnaire forwarded some time ago, I hope to be able to send you a summary of the research in the near future. My reason for writing this time is to tell you about another stage of the research. Your account and others has mentioned the role played by your husband during your illness. Both I and my supervisors feel it would be a very important contribution to the research to discover more about the experiences of those who were closest to women during their experience of pre-eclampsia. I note from your questionnaire that your husband was with you most during your illness. I would like very much to talk to him and am writing to you to seek permission to make contact with a view to interview him. I would only do this with your full consent of course. Like your interview, I am concerned with his thoughts and feelings on the experience of pre-eclampsia, though obviously from the perspective of the 'witness' or 'supporter'. I hope very much that you will feel able to give your consent. If this is the case I would be grateful if you could give me a contact address and/or number so that I may explain to him personally the purpose of the research and issues of confidentiality and seek his consent to participate. I would be grateful if you could complete the form enclosed and forward it to me using the self addressed envelope. Once again, I hope you and your family are keeping well.

Best regards

Julie Savage

APPENDIX 9

Name:

Address:

I do **not** wish you to make contact with the person/persons with me most during my experience of pre-eclampsia []

I do **consent** to you making contact with the person/persons with me most during my experience of pre-eclampsia []

Please state the relationship of the person/s:

Name and address and/or contact number of person/s above

Name:

Address:

Telephone:

Name:

Address:

Telephone:

Thank you for completing this form. Please forward it to me using the stamped and addressed envelope.

APPENDIX 10

My Name
My Address
My Telephone Number

Dear,

A few months ago I interviewed your daughter about her experience of pre-eclampsia. I have recently contacted..... again informing her that the research is now entering a second phase. As well as researching women's experiences of pre-eclampsia, I am now also interested in the experience of those persons who were most closely involved during their illness. Your daughter kindly gave me permission to contact you with information about the research and to ask whether you would consider participating. The research is being carried out with supervision from both the Open University and Institute of Health Services Research at Luton as part of my Doctorate. I would like to talk to you about your thoughts and feelings as one of the persons who shared the experience with The discussion will be informal, taking the form of a conversation rather than a 'question and answer' session. With your permission I would like to record the conversation using a tape machine. **At no point will your name be written or verbally communicated anybody else. If you do agree to participate I can assure you of complete confidentiality and anonymity.**

I hope very much that you do decide to participate in the research. Please complete the attached form to indicate your choice and return it to me using the stamped and addressed envelope provided. **At any point prior to or during our conversation you are of course completely free to decide not to participate any longer.**

Yours sincerely

Julie Savage

I would like to take part ()

*I would **not** like to take part ()*

Name:

Address:

Telephone:

I will contact you to arrange a time that is convenient for you

Interview Schedule

Prompts

In what ways?
Could you tell me more about that?
Can you give me an example of that?
How did you feel about ...?

Introduction

Thanks

Confirm acceptability of recording

Issues of confidentiality

Explain about respondents right to have recording suspended etc

Begin recording

The experience of pre-eclampsia

Phrasing: Can you describe to me your experience of pre-eclampsia?

Areas:

Awareness/response to initial symptoms

Memories/response/feelings to medical care, attitudes, decision making

Reaction of others

Feelings about cause of illness

Neo natal experience

Post Pre-eclampsia (first few weeks)

Phrasing: could you describe to me what the first few weeks were like when you came home?

In what ways did having pre-eclampsia affect you during this time?

Areas:

Personal consequences: emotional, social, physical
Relationship with baby
Support received

Thinking back

Phrasing: Phrasing: Thinking back to the early stages of your pregnancy, could you describe to me what you expected pregnancy to be like?

Image of pregnancy
Information received about complications/pre-eclampsia
Ideas on natural childbirth

Reflections

Phrasing: Looking back, how do you now feel about...?

Areas:
Pregnancy: expectations past and now
Medical care and support
Improvements to care and treatment

Closure

Phrasing: is there anything that you thought I would talk with you about that I haven't?

Motivation: Phrasing: Can I ask why you agreed to talk to me today?

Questions: Phrasing: are there any questions that you would like to ask me about my research?

Thank you

Tape Off

Record basic interviewee details

Interview Schedule for Significant Others (with phrasing)

Prompts:

In what ways?
Could you tell me more about that?
Can you give me an example of that?

Introduction

Thanks
Confirm acceptability of recording
Issues of confidentiality
Explain about respondents right to have recording suspended etc

Begin recording

The experience

Phrasing: Can you describe to me what it was like for you as the (partner, husband, mother) of someone who suffered from pre-eclampsia?

Areas:

Awareness/response to initial symptoms
Memories/response/feelings to medical care, attitudes, decision making
How they tried to support and were supported
Neo natal experience

Post Pre-eclampsia

Phrasing: could you describe to me what the first few weeks were like when your...came home?

Areas:

Personal consequences: emotional, social, physical
Relationship with baby

Support received
How they supported and were supported

Reflections

Phrasing: Looking back, how do you now feel about...?

Areas:

Medical care and support
Improvements to care and treatment

Closure

Anything else to tell (Phrasing: is there anything that you thought I would talk with you about that I haven't?)

Motivation (Phrasing: Can I ask why you agreed to talk to me today?)

Questions? (Phrasing: are there any questions that you would like to ask me about my research?)

Thank you

Tape Off

Record basic interviewee details

Experiences of Pre-eclampsia

These are a list of areas that you *might* like to write about but please feel free to write about *any* area that was important to you.

Before Pregnancy

Your perception and expectations of pregnancy. For example, what words would you have used to describe it?

Your awareness and understanding of pregnancy complications

Pre-eclampsia

Your reactions and thoughts with the early symptoms. For example, did you think there was a problem? Or did you feel that there was no need for concern?

Your reaction when told it was pre-eclampsia

A description of the events and your reaction to them from the time pre-eclampsia was confirmed.

Your reflections on the level to which to felt you were informed about the illness and its consequences.

Dealing with your baby. For example, what was your experience of the special care baby unit?

Post pre-eclampsia

Thoughts and feelings during the first few weeks at home.

Feelings on the care received and in what ways, if any, it could have been improved.

Your attitude towards pregnancy now.

APPENDIX 14

The following notice was placed in the newsletters of two charities during April and May 2000: Baby Life Support Systems (BLISS) and Action on Pre-eclampsia (APEC). A further was placed within the national magazine Baby care and Pregnancy (April, 2000 edition).

‘Have you suffered from pre-eclampsia and/or eclampsia within the last two years? I am conducting research into the experiences of women who have suffered from these illnesses. If you live in the Hertfordshire, Bedfordshire, Buckinghamshire or London are and feel you might be interested in talking to me about your experiences, please contact me. My Name, My Address, My Telephone Number.